Maternal and Child Health Services Title V Block Grant

State Narrative for Kansas

Application for 2010
Annual Report for 2008

Document Generation Date: Monday, September 28, 2009

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

/2010/ To obtain a copy of the signed Assurances and Certifications, contact:

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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

/2010/ In order to solicit public review and comment as in [Section 505(a)(5)(F)], a notice requesting public input was posted on the Kansas Rural Health Information System, the public health information system with postings to all local health departments, hospitals, primary care clinics and other health care providers.

Two weeks in advance, on March 5, a notice of public hearing was announced in the Kansas Register, the official newspaper for the state of Kansas. The notice solicited participation and comments from interested persons on the state plans for the Maternal and Child Health Services Block Grant and also for the Preventive Health and Health Services Block Grant administered by the Kansas Department of Health and Environment. On Wednesday, March 18, the hearing was held at 9:00 a.m. before the House Appropriations Committee in the State Capitol Building.

The hearing included a presentation by KDHE Director of Health on the federal requirements for each of the block grant programs, the services provided in Kansas, and the use of the federal funds.

There were questions about flexibility in use of the funds and supplantation restrictions by the federal government. //2010//

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Needs Assessment Summary

1. In order to determine state MCH priorities for the five year period 2006-2010, a formal MCH state needs assessment was conducted in 2004-2005. The needs assessment conformed to federal requirements to determine the state priorities for each of the three MCH population groups. This project and its products were called MCH2010. A final document was prepared and public input was solicited and incorporated. The final report was submitted to the MCHB in July of 2005 as part of the MCH Block Grant Application. The document is available to the public at http://www.kdheks.gov/bcyf/. Nine MCH state priorities were identified through the 5-Year MCH State Needs Assessment process. Three for each MCH population group:

Pregnant Women and Infants - Increase early/comprehensive health care before, during, and after pregnancy;
Reduce premature births and low birth weight; Increase breastfeeding.

Children and Adolescents - Improve behavioral/mental health; Reduce overweight; Reduce injury and death.

CSHCN - Increase care within a medical home; Improve transitional service systems for CSHCN; Decrease financial impact on CSHCN and their families.

/2010/ Since the submission of the last MCH Block Grant application there have been no changes in the Kansas state priority needs. An attachment to this section provides information about any changes in the population strengths and needs in the State priorities since the last Block Grant application. //2010//

2. The MCH2010 process built on lessons learned in the previous two needs assessments. Quantitative and qualitative data were still used, but the process was organized around stakeholder involvement and decision-making. An MCH planning team consisted of the BCYF Director, Children & Families Section Director (representing both the pregnant women & infants and children & adolescents population groups), Children with Special Health Care Needs Section Director. In addition, two MCH epidemiologists, a contracted project manager, and the three facilitators (one internal to BCYF and two contracted facilitators), as well as a consultant from Johns Hopkins University Women's and Children's Health Policy Center (assistance in MCH capacity assessment) provided support to the project.

Three one-day meetings with over 70 stakeholders were held from June 2004 through October 2004. The stakeholders broadly represented MCH concerns in Kansas and included family representatives, adolescents, health care providers, and program staff as well as representatives from other state agencies, local health departments, universities, not-for-profit organizations, and advocacy groups.

Each of the meetings with stakeholders was structured to accomplish specific tasks in a sequence leading to identification of priorities. After a plenary session setting the objectives for the workday, stakeholders broke out into "panels of experts" to focus on one of the three MCH population groups. The first meeting provided an overview of the needs assessment process and stakeholders reviewed data indicators and identified data needed for the work in the second

meeting. At the second meeting stakeholders reviewed data, selected priorities, and identified some possible strategies to address priorities. The focus of the third meeting was evaluation of MCH capacity to address priorities. The needs assessment process continues through the implementation of activities described in the State Performance Measures section of this application. Performance measures are assessed on an annual basis to track on progress in addressing the priorities.

/2010/ An attachment to this Section provides information about any changes in the State MCH program or system capacity in those State priorities since the last Block Grant application. //2010//

3. The needs assessment process has been invaluable in partnership building and collaboration with multiple stakeholders in the state. Many participants expressed appreciation for the opportunity to share their opinions and expertise. An important factor in the needs assessment process was consideration of the role of all stakeholders and of multiple and diverse partners in the broader state MCH system and their roles in addressing MCH priorities. As well, the process educated many stakeholders about the breadth and importance of the State MCH system and the role of the State MCH agency.

/2010/ An attachment to this Section provides a brief description of ongoing needs assessment activities, such as data collection and analysis, evaluations, focus groups, surveys, that enable the State to continue to monitor and assess, on an ongoing basis, its priority needs and its capacity to meet those needs. //2010//

4. The stakeholders themselves selected the State priority needs during the Kansas needs assessment process. They were given lists of indicators at the first meeting from which they selected the data they needed to review for the work of the second meeting. They were guided in their decision-making process by the quantitative data, but they were also encouraged to utilize their knowledge and backgrounds as expert panelists to select priorities. In general, as evidenced by the written feedback from stakeholders, the process was very satisfactory to all not only in selecting priorities but also in forging relationships to support MCH activities in the state.

/2010/ Please see the attachment for a brief description of any activities undertaken to operationalize the 5-year needs assessment, such as establishing an advisory group to monitor State progress in addressing the findings and recommendations resulting from the needs assessment. //2010//

An attachment is included in this section.

III. State Overview

A. Overview

This section puts into context the MCH Title V program within the State's health care delivery environment. It briefly outlines Kansas' geography, demography, population changes, and economic considerations. The overview provides an understanding of the State Health Agency's current priorities/initiatives and the Title V role in these. It includes a description of the process used by the Title V administrator to determine the importance, magnitude, value, and priority of competing factors impacting health services delivery in the State including current and emergent issues and how these are taken into consideration.

Geography/Demography

Located in the central plains region of the United States, Kansas encompasses 81,815 square miles (about 2% of the land area of the U.S.). It is bordered on the north by Nebraska, on the south by Oklahoma, on the east and west by Missouri and Colorado respectively. Hills, ridges and wooded river valleys in eastern and central Kansas give way to the flat, dry, treeless High Plains of the western part of the state.

With a 2000 Census total population of 2,688,418, Kansas ranks 32nd among the states, about 1% of the U.S. population. This represents an 8.5 percent increase over the 1990 Census. /2008/ Kansas increased in population from 2,735,502 residents in 2004 to 2,744,687 residents in 2005, a 0.3% increase. //2008// Geography, climate and economic resources combine to influence the population distribution of the state. The four most populous counties, Johnson, Sedgwick, Shawnee and Wyandotte, are located in the eastern and central parts of the state. The least populous counties are located in the western part of the state. In 2003 the population density of Kansas was 33.3 persons per square mile compared with 82.2 persons per square mile for the U.S. The county population density ranged from 1,040 persons per square mile in Wyandotte County in eastern Kansas, Kansas City area, to less than six persons per square mile in one far western county. Two counties in western Kansas had population densities of 1.8 persons per square mile. /2009/ Based on the July 1, 2006 Census data, Kansas' population of 2,764,075 is 0.9% of the U.S. population. This is due to the slower growth rate for Kansas (0.6%) than for other States in the country, most notably the sunbelt States, e.g., Arizona at 3.6%. For comparison purposes, the overall growth rate for the U.S. for this period was 1.0%. //2009//

/2010/ The proportion of Kansas children living in metro areas of the state continues to rise. Over sixty percent (62.7%) of children now live in metropolitan areas. This is up from 60% last year. Urban areas with 74.8% of children, continue to gain, while rural (22.5%) and frontier counties (2.6%) lose children as their families migrate to metro/urban areas for jobs. //2010//

Population Changes

Historically, Kansas has been predominantly rural. However, that trend is changing along with a similar trend for the U.S. The total population of all cities in Kansas is 2,211,271 or 81.2 percent of the total population (2003). /2008/ this was 81.4% in 2005. //2008// /2009/ and 81.7% in 2006. //2009// Of the 20 largest cities in Kansas, five have populations that exceed 100,000 including Wichita (354,617), Overland Park (160,368), Kansas City (145,757), Topeka (122,008), and Olathe (105,274). These cities are all located in the eastern half of the state. The western half of Kansas has five of the 20 largest cities in Kansas, including Salina (45,833), Garden City (27,216), Dodge City (25,568), Liberal (20,067), and Hays (19,915). /2009/ Last year, 34.3 percent of the total population resided in rural areas and cities with populations of less than 5,000. //2009//

In 2000 the population of the state was 86.1 percent white, 5.7 percent African American, 1.7

percent Asian, 0.9 percent American Indian or Alaska Native, some other race or mixed heritage 5.5%. /2008/ The 2005 population estimates put the percent white at 89.4 and Black at 5.9 percent. //2008// Native Hawaiians and other Pacific Islanders numbered 1,313. Seven percent (7%) of the population reported Hispanic ethnicity. Immigrants or foreign-born residents accounted for only 2.5 percent of Kansas' total population.

Over the past decade, Kansas has seen an increase in the diversity of its population. From 1990 to 2000, the Hispanic population increased by 101% to 188,252 (or 7.0 percent). The Asian and Pacific Islander population increased 48,119 (51.6 percent). The American Indian and Alaska Native population increased 24,936 (13.5 percent). The African American population increased by 7.8 percent to 154,198. The increase for the white population over the same period was only 3.7 percent (2,231,986 to 2,313,944). /2008/ According to 2005 population estimates, 89.4% of Kansans were White and 5.9% were Black. Hispanics made up 8.3% of Kansas' population. //2008// /2009/ According to 2006 population estimates, 81.1% of Kansans were White non-Hispanic and 5.7% were Black non-Hispanic. Hispanic made up 8.6% of Kansas population (a 3.6% increase from 2005). //2009// ***/2010/ According to 2007 population estimates, 80.7% of Kansans were White non-Hispanic and 5.8% were Black non-Hispanic. Hispanics made up 8.8% of Kansas' population (a 2.3% increase from 2006). //2010//***

Approximately 8.7 percent of the Kansas population five years of age and older speak a language other than English at home according to the 2000 Census. Of these 3.9 percent speak English less than 'very well.' Between 1990 and 2000 there was a 66% increase in the population speaking a language other than English in the home. The Kansas percent increase was greater than the average increase for the Midwest (66% versus 43%) but considerably less than the increase for the South (62%).

Kansas has slightly fewer than 40,000 live births each year (39,353 in 2003). /2008/ 38,654 in 2004 and 39,701 in 2005 //2008// ***/2010/40,896 in 2006, and 41,951 in 2007. //2010//*** In 2003, the Kansas birth rate of 14.4 was 2.9 percent higher than the national rate of 14.0. ***/2010/ The birth rates for 2004 through 2007 remained well above the rates for the U.S. at 14.5, 14.5, 14.8, and 15.1 respectively. //2010//*** Seward, Geary and Finney counties had the highest five-year county birth rates of 23.7, 22.3, and 21.2 births per 1,000 population respectively. In 2003, 27.1 percent of the population (736,901) were children ages 18 and younger. Women of reproductive age 15-44 accounted for 20.9 percent of the population (568,347).

During the period 2000 through 2003, 54% of births occurred in 5 urban counties with 77% (180) of Kansas obstetricians practicing in 5 counties. The remaining 100 Kansas counties account for 46% of all births where 23% (54) of the state's 234 obstetricians are in practice. Forty-two of 105 counties have no maternity services. Ten counties have no hospitals. /2008/ Six hospitals have over 100 NICU admissions per year. //2008// Thirty-seven (37) rural and frontier counties average fewer than 40 births per year.

Economic Considerations

Compared to the U.S. population (2003), a lower percentage of Kansans live in households with incomes below the federal poverty level (10.8% versus 12.5% for the U.S.) and a lower percentage of children under age 18 live in households with incomes below the federal poverty level (14.5% versus 17.6% for the U.S.). Twenty percent (20.1%) of Kansas' children living in poverty are of Hispanic ethnicity. Overall, the percent of Kansas' families living at or below the federal poverty level is 6.7%. Poverty is more common in Kansas' families headed by single females and those with children under the age of five in the household, regardless of race or ethnicity. Most Kansas children under age 18 living in poverty live in three population centers: Sedgwick Co. (Wichita), Wyandotte Co. (Kansas City, KS) and Shawnee Co. (Topeka).

/2008/ The population of school age children 5-19 years of age totaled 569,356 in 2005. This is a 10,307-person decrease, or -1.8 percent since 2004, and a 40,354-person decrease, or -7.1

percent since 2000. In 2000, school age children represented 22.7 percent of the Kansas population (21.2 in 2004, 20.7 in 2005, 21.1in 2006). //2008//

Educational attainment for Kansans is favorable compared to the U.S. About 86.0% of Kansans age 25 and older are high school graduates compared to about 80.4% for the U.S. The percent of those ages 25 and older with college degrees is slightly higher for Kansas than for the U.S. (25.8% versus 24.4%).

Following the 2001 national economic downturn, Kansas' economic recovery has been more modest than the U.S. economic recovery. Even though the state experienced overall employment growth in 2004, the economy is expected to continue modest growth below that of the U.S. in 2005. The monthly average unemployment rate for 2004 was 5.5%. /2009/ The unemployment rate for Kansas decreased from 4.3 percent in October 2006 to 3.4 percent in October 2007. //2009//

/2010/ This year, there was a slight increase (0.1%, -593) in the number of Kansas children ages 0-19, with largest growth among African-Americans. This age group population has become increasingly diverse: 87% white, 9% African-American, 1% Native American and 2% other. Kansas Hispanics account for 15.9% of children in the 0-19 age grouping, about 1 in 7. Possibly in response to the continuing economic downturn, enrollment of 0-19 age children has increased in several government assistance programs: Medicaid, SCHIP, food stamps, and WIC. Similarly, high school drop out rates and juvenile crime rates have increased in this reporting year. //2010//

Health Care Delivery Environment

In Kansas, total state health expenditures per capita for state fiscal year 2001 was slightly lower ($3,275) than for the U.S. ($3,590). The total includes both state-funded operating and capital spending. For state fiscal year 1999, Kansas state health care expenditures per capita was lower ($698) than for the U.S. ($872).

In 2005, there were eleven federally qualified health centers with sites in Kansas and 173 federally certified rural health clinics. There are 117 community hospitals of which 76 are Critical Access Hospitals. With 175 physicians per 100,000 population, Kansas was lower than the national ratio of 198 physicians per 100,000. Kansas ranked 31st among states in physicians per capita. There were 5,407 active patient care physicians in Kansas in 2003. Twenty-five percent of active patient care physicians are female (1,354).

The rate of registered nurses per 10,000 population in Kansas was slightly higher than the U.S. This was equal to 883.1 RNs per 100,000 population in Kansas in 2000 compared to 780.2 for the U.S. Registered nurses include advance practice nurses such as nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists. There were 1,685 dentists, 2,020 dental hygienists, and 2,840 dental assistants practicing in Kansas in 2000. There were 62.6 dentists per 100,000 population in Kansas in 2000, slightly below the national rate of 63.6. The per capita ratios of dental hygienists and dental assistants were higher than their respective national rates. The number of dentists in Kansas increased 38% between 1991 and 2000 while the state's population grew 8%. The result was a 28% increase in dentists per capita compared to a 16% increase nationwide.

Overall, there were more than 126,000 people employed in the health sector in Kansas in 2000, 9.6% of Kansas' total workforce, higher than the national rate of 8.8%. Kansas ranked 13th among states in per capita health services employment. In 2000, Kansas ranked 8th among states in the number of hospital beds per 100,000 population.

According to the U.S. Census Bureau's Current Population Survey, in 2003, 11.0% of all Kansans had no insurance coverage. This compared favorably with data for the U.S. population at 15.6%

uninsured. Eighty-nine percent (89.0%) of Kansans were covered by private or government health insurance, compared to 84.4% for the U.S. /2008/ Nationally, the number of people with health insurance coverage increased by 1.4 million in 2005 from 245 million in 2004, to 247 million in 2005. In the U.S., the total number of insured represents 84.1% of the U.S. population. For the same period 2004 to 2005, the number of Kansans covered by private or government health insurance increased from 2,372,000 (88.9% of the Kansas population) to 2,405,000 (89.2%). //2008// /2009/ In 2006, the U.S. Census put Kansas overall uninsurance rate at 12.3%. Eighty-seven percent (87.7%) of the Kansas population had public or private health insurance coverage. This compares favorably to U.S. rates for uninsurance at 15.8% and insured at 84.2%. //2009//

According to the 2001 Kansas Health Insurance Study, children are disproportionately affected by lack of health insurance coverage with approximately 8% of Kansas' children age 18 and under uninsured. Over two thirds of Kansas children were covered by private insurance and fifteen percent were covered by public insurance. Similarly, women of reproductive age (15-44) are dispropportionately affected by lack of health insurance coverage with 13.2% uninsured compared to 12% of the Kansas population. Of those with coverage, 82.6% were covered by private insurance and only 4.3% by public insurance.

The same study put the average annual growth of Medicaid enrolled at 5.6% in Kansas compared to 9.8% for the U.S. Fifty-two percent (52%) of Kansas Medicaid enrollees are age 18 or younger. Kansas maintains the eligibility level for the Medicaid program at the federally required minimum. See Form 18 for eligibility levels for Medicaid and State Children's Health Insurance Program (SCHIP), called the Health Wave program in Kansas.

/2009/ A Kansas Health Institute study published in February of 2008 updated the health insurance data for the State using the March 2007 Current Population Survey. Key findings of the report are the following: the percent of children covered by private insurance declined from 66.6 percent in 2004-05 to 63.0 percent in 2005-06. Children's enrollment in Medicaid and the SCHIP program declined in SFY 07 after steady increases for several years, possibly due to new citizenship documentation. The percent of all Kansans who are uninsured increased from 10.5 to 11.3 percent from 2004-05 to 2005-06, following 5 years of relative stability. The overall percent of children uninsured showed a slight increase from 6.5 to 7 percent, although the finding was not statistically significant. The percent of adult Kansans uninsured increased significantly from a six-year low of 13.5 to 15.5 percent. Poverty is on the rise in Kansas with the number of uninsured Kansans living in poverty increasing significantly to 95,140 in 2005-06 up from 68,602 in 2000-01. //2009//

Among Kansas Medicaid enrollees, 55.3% are enrolled in managed care compared to 58.3% for the U.S. The percentage of Medicaid spending on children under age 18 (15%) in Kansas is the same as for the U.S. However, long-term care (fee-for-service) Medicaid spending is higher (53%) compared to the U.S. (38%). The number of births financed by Medicaid in Kansas rose from 7,718 (23% of Kansas live births) in 1999 to over one third in 2002. Joint application was allowed for children's Medicaid and SCHIP-funded separate programs starting in 2002. Kansas is one of 18 states in the U.S. with 12-month continuous eligibility for Medicaid eligible children. Due to budget shortfalls, Kansas has followed the lead of other states in implementing cost-sharing requirements for the Kansas SCHIP program but not decreasing benefit levels. Kansas has not applied for a waiver to expand eligibility for Medicaid services to women from the existing 60 days postpartum to 2-5 years as has been done in several other states. ***/2010/ At a June 2009 legislative hearing, the director of the Kansas Health Policy Authority, the Kansas Medicaid agency, said that budget cuts to the agency of about 15.5% or $3.5 million will probably require more cuts for the 2010 State Fiscal Year. He said 30,000 to 50,000 people will be delayed Medicaid or Children's Health Insurance Program (SCHIP) applications beginning in December, and that about 10,000 Kansans are now in jeopardy of a delay of processing applications for the State/federal programs. There have been about 13 layoffs at the agency and another 30 jobs could be lost through retirements or keeping jobs***

vacant. Customer service both for program participants and for health care providers will be reduced by about 40%, and as an outcome providers will not be able to quickly learn whether a patient is covered by a program or for pharmacists to learn whether they will get paid for drugs they provide. This could mean delays for people who need the drugs and/or other services. //2010//

Kansas has no laws requiring coverage of all FDA-approved prescription contraceptives by all health insurance policies written in the State that provide prescription coverage. There is no mandated coverage for infertility diagnosis and treatment. However, there is mandated direct access to OB/GYN limited to one visit per year from an in-network OB/GYN. OB/GYNs are not mandated as primary care providers. Kansas law mandates benefits for breast and cervical cancer screening. Kansas laws also require insurers to provide coverage for diabetic supplies, equipment, and/or out-patient management training. Insurance coverage of newborn metabolic and newborn hearing screening is not mandated.

Even though insurance coverage and financing mechanisms dominate policy discussions about the health of Kansans, there is a strong role for public health in prevention and early intervention, health promotion, and basic gap filling services. The state health agency operates within a framework of legislative authority. In partnership with 99 local health departments operating in 105 counties, the state health agency carries out its public health mandate.

State Health Agency's Current Priorities or Initiatives & Title V Role

/2009/ Going into the 2008 legislative session, the Kansas Department of Health and Environment (KDHE) health priorities and initiatives included the following: enhanced funding for the Part C Infant Toddler Program, Primary Care Safety Net Clinics funding, Coordinated School Health Program, and support for the Kansas Health Policy Authority (KHPA) 21-point health care reform agenda.

The health care reform agenda (www.khpa.ks.gov) was a major agenda for the Governor, the KHPA, and KDHE going into the 2008 session. Agency administration and the Director of Health were involved in the formulation of the agenda which included various components of the Healthy Kansans prevention plan. Among the provisions of the agenda were the following: define medical home in statute/regulation; increase provider reimbursement; implement statewide community health record; promote insurance card standardization for public insurance programs; increase tobacco user fees; statewide ban on smoking in public places; expand health and wellness programs in partnership with community organizations; add Commissioner of Education on KHPA Board; statewide surveillance system for obesity of school children; promotion of healthy food choices in schools; increase in physical activity in schools; wellness grant program for small business; promote healthier food options for State employees; dental cae for pregnant women enrolled in Medicaid; expansion of cancer screening through State breast cancer program; improve enrollment of children in HealthWave (Medicaid/SCHIP), allow parents to keep young adults on their family insurance plans through age 25, and develop inexpensive young adult policies; premium assistance program for adults in poverty (>100% FPL); assistance to small businesses for affordable coverage. Total cost for the 21-point package was $159.88 million with $86 million from State funds.

The following provisions had been adopted by the close of the 2008 legislative session: medical home definition; Commissioner of Education on KHPA Board; study of young adult insurance policies; studies of small employer policies; transfer of cafeteria plan from Dept of Commerce to KHPA; funding for continuation of Comprehensive School Health Program at $550,000 per year. There was no action on tobacco use fees or statewide ban on smoking. The following provisions passed with no appropriation: insurance card standardization; statewide community health record; dental coverage and tobacco cessation for pregnant women enrolled in Medicaid; improved access to public insurance for children and young adults; and improved access to cancer screening.

An additional $1 million tobacco settlement funds was appropriated for the Part C (tiny-K) program that serves children ages birth to two years of age with disabilities and their families. The program located within the Bureau of Family Health complements the program serving 3-5 year olds (Part B Special Education program) in the Kansas State Department of Education.

The agency requested $154,000 for primary care safety net clinics to assist them with the rising costs of providing services in underserved communities. The Kansas Association for the Medically Underserved (KAMU) proposed a separate plan estimated to cost between $6.1 and $8.6 million, to accommodate a 10-20 percent increase in patient visits for uninsured persons; provide additional outreach for enrolling eligible individuals in Medicaid and SCHIP; allow for increased recruitment of physicians and dentists; and other. Primary Care Safety Net Clinics received additional funding of $2.5 million to serve the uninsured after the legislature rejected many of the Medicaid and SCHIP expansion provisions of the KHPA health care reform plan. The legislature appropriated an additional $1,645,000 for primary clinics plus an additional $855,000 for capital expenditures.

Since the $500,000/year 5-year CDC grant, Coordinated School Health, was set to expire in 2008, KDHE supported an extension using state general funds. The program was a joint effort between KDHE and the State Department of Education focusing on increased physical activity, nutrition, decreased tobacco use, and obesity prevention and reduction. The legislature appropriated tobacco settlement funds at $550,000 to continue the effort.

The State Agency also supported expansion of the newborn screening program to the core panel of 29 conditions recommended by the ACMG. This received early approval in the session with appropriation of an additional $1.3 million for the KDHE Public Health Laboratory and $336,000 for follow-up and treatment through the Bureau of Family Health, all through tobacco settlement funds. The legislature specified a start-up date of July 1, 2008.

The Agency continued to resist efforts by interest groups to dilute health and safety portions of the child care licensing program. Child care labor unions are also emergent as a force in the State bringing another constituency into the arena of child care licensing and regulation. Many bills were introduced to restrict state-funded services to immigrants, penalize employers who hire immigrants, and the Agency provided numerous briefings to legislative committees. None of the bills passed. //2009//

The KDHE continues to work towards an integrated public health data system in partnership with local agencies. As such, the new databases for MCH and CSHCN interface with the web-based Immunization Registry. Plans are underway to develop additional interfaces with WIC, birth defects surveillance, and other programs within the department. These efforts, in turn, link with the development of public health performance measures as a prelude to advancement of a Public Health Standards/Accreditation process for the State. ***//2010// Kansas is one of sixteen participating states in the National Network of Public Health Institute's Multi-State Learning Collaborative -- 3 (MLC -- 3). The Kansas MLC -- 3 effort consists of three regional teams: 8 counties in the southeastern part of the state; the northeast corner counties; and a state agency team at the KDHE. Throughout the learning collaborative process, each of the teams has been involved in mini-collaborative projects first targeting the reduction of infant mortality with a specific target of improving access to prenatal care in the first trimester. In the second mini-collaborative, community health assessments are the focus with a specific target of developing community health profiles. Currently, Kansas is working on the first target of reducing infant mortality by improving access to prenatal care in the first trimester. A major component of the project is testing regionalized efforts in public health since regionalized approaches will likely be needed for many county health departments to be accredited in the future. For more information on the Kansas MLC -- 3 go to: http://www.kalhd.org/MLC3 //2010//***

Meanwhile, the State Early Childhood Comprehensive Systems (SECCS) grant stakeholders incorporated into their state plan the components from the Governor's school financing plan relating to young children including all day kindergarten, increased support for 4 year old at-risk programs, and funding for evaluation of Parents as Teachers. In turn, the Governor endorsed the SECCS plan and staffers are participating in the implementation process.

/2007/ The 2006 legislature passed a 3-year education spending bill which fell short of increases recommended by both a private consulting firm and the research wing of the legislature, Legislative Post Audit, but there were no tax increases. The spending bill included funding for the Governor's recommended pre-K pilot projects. The legislature did not consider funding for universal pre-K and all day kindergarten. //2007// /2008/ The 2007 Kansas Legislature appropriated $500,000 to improve access to child care for infants and toddlers, plus $10.5 million for child care subsidies for low-income working parents, $1.6 million for expansion of Early Head Start to 70 counties, $3 million for expansion of the pre-K pilots, and $400,000 for after school programs. The most significant development of the session relating to early childhood issues, was near passage of a bill to create a separate Office of Early Childhood through a reorganization of programs servicing the 0-5 age group into one entity. This bill stalled out but a study group was named to make recommendations to the 2008 Legislature. Other developments included selection of Kansas as one of 18 stated to work on the ABCD Screening Academy, a Commonwealth Fund and NASHP effort. Kansas was selected as one of 10 states for a $10,000 grant from the NGA for an Early Childhood Summit. //2008//

The second most important policy agenda was expanding eligibility while at the same time holding down health insurance costs. The Governor's Office proposed creation of a health authority within the Office of Administration that would combine Medicaid, SCHIP, and the State Employees Health Insurance programs to obtain greater purchasing power, and lower prescription drug and administrative costs. During the 2005 legislative session, the proposal was reworked by the majority party and passed. The legislators maintained the key points of combining programs/purchasing power. The plan diverged by establishing a separate State agency more answerable to the legislature while at the same time appropriating no funding for a separate state agency.

The timeline for the current plan (House Substitute for Senate Bill 272) is as follows: July 1, 2005 Kansas Health Policy Authority established; July 1, 2005 transfer programs from Kansas Department of Social and Rehabilitation Services (SRS) to Dept of Administration, Division of Health Policy and Finance; January 1, 2006 Assumption of Responsibilities by Authority; March 1, 2006 Authority Plan Submitted to Legislature; July 1, 2006 Transfer programs to the Authority; Beginning of 2007 Legislative Session - Plan submitted for transfer of additional Medicaid funded programs to the Authority (could include mental health services, Home and Community-Based Services waivers, nursing facilities, substance abuse prevention and treatment and the state hospitals); Beginning of 2008 Legislative Session - Plan submitted to legislature for assuming responsibility for purchase of health care services for Dept. of Aging, Dept. of Corrections, Juvenile Justice Authority, Dept of Education - Local Education Agencies (LEAs).

/2007/ July 1, 2006 is the date for completion of the transfer from Executive branch control to control by a governing body appointed by both legislative and executive branches. Also, the directorship of the HPA is unclear as the executive director will serve at the pleasure of the governing body. //2007//

At least one area of KDHE will be impacted by this major reorganization, the Center for Health and Vital Statistics (CHES). The administration of the Health Care Data Governing Board and staff to that board currently reside in the CHES Office of Health Care Information. Administration and staffing are expected to transfer to the new state agency in January of 2006. The impact of this transfer on access to hospital discharge and other data by state health department programs cannot be determined at this time. /2007/ Management and control of data sets is still undetermined at this time. //2007// /2008/ SB 11 of the 2007 session directs the KHPA to

develop a plan to move to universal coverage. The plan will be presented to the 2008 session. Meanwhile, the bill provides assistance to families with incomes below 100% FPL to purchase private coverage. It provides grants and loans to small businesses to form group plans. There are loans to safety net clinics. //2008//

Federal legislation requires coordination between Title V and Title XIX of the Social Security Act (MCH and Medicaid). The SRS/KDHE Interagency Agreement spells out the relationship between the state Medicaid agency and the state MCH agency in Kansas. It is certain that the interagency agreement will need to be reviewed in light of these recent changes in Kansas. Meanwhile, MCH/CSHCN acts in an advisory capacity to the state Medicaid agency relating to services for pregnant women and children. Another advisory role is to the state insurance agency and to the legislature in insurance matters relating to pregnant women and children.

Although it has not received funding, the health promotion portion of the Governor's health plan, based on a similar plan in the state of Arkansas, has been implemented through the Office of Health Promotion in KDHE. The focus is on nutrition and physical activity in the work place and in the community with school-age, adult and elderly populations. School age efforts are coordinated with the Department of Education through CDC's Coordinated School Health grant to Kansas. Maternal and Child Health staffs participate in the state advisory group for the Coordinated School Health project and provide an important link to school nursing services in the state. The Coordinated School Health program links with health education and physical education teachers and the school nutrition services mandated by the Child Nutrition Act.

In the Spring of 2005, Healthy Kansans 2010 was launched by the Office of Health Promotion within KDHE. PowerPoint data presentations with recommendations were provided by individuals from within and outside KDHE relating to Healthy People 2010 priorities. At the final meeting of the consensus group, the participants were asked to vote on the key priorities for KDHE for the next 5 years, keeping in mind the presentations and the 10 leading health indicators. Following are the three priority areas selected by participants: 1) Health & Disease Disparities; 2) Early identification and interventions (women and children); 3) Systems interventions to deal with Social Determinants of Health. Workgroups were formed around each of the three priority areas and each recommended strategies in the following areas: improved communications regarding health and public health; ongoing workforce development; surveillance and data needs; coordination and collaboration of programs. MCH/CSHCN continues to participate in this effort to establish a linkage with other planning efforts such as MCH 2010 and SECCS.

/2007/ Highlights of Kansas' legislative activity in 2006 relating to maternal and child health included: three year school finance plan; passage of the child passenger safety seat referred to elsewhere in this document under injury prevention; continued discussion but no passage of emergency contraception education by public health; supplemental appropriation for CSHCN for treatment products; HB 2284 right to breastfeed as needed in a public place and jury duty deferment when breastfeeding; mental health parity; school vending machines and nutritious food in schools; requiring liability insurance for day care; domestic violence-battery; services for undocumented individuals; cord blood bank education; establishment of dental residency program in Wichita; amendments to laws concerning the state trauma program; new requirement of meningitis vaccine for incoming college students.

Appropriations highlights for the session relating to maternal and child health included: PKU treatment supplemental of $100,000 state funds for SFY 06 and $208,000 Tobacco Settlement funds for PKU in SFY 07; $110,000 SGF for the Wichita cerebral palsy seating posture seating program; $1,850,000 increase for the Part C Infant-Toddler program; $415,000 for Dentistry Residency Training program; $50,000 additional funds for SIDS Network of Kansas; $200,000 increase for Pregnancy Maintenance Initiative; $50,000 for Newborn Hearing Loaner Program; $380,000 for Cord Blood Bank education; $225,000 for Domestic Violence Training; and $250,000 for Youth Mentoring program. There was a great deal of discussion about funding for expansion of the Kansas newborn screening program to 29 tests recommended by the American

College of Medical Genetics and a $2 million proposal was not passed. At the same time federal reductions in recent years from Maternal and Child Health Block Grant and Preventive Health Block Grant necessitated a 6.59% across the board reduction to local MCH agencies. CSHCN continues to tighten its belt due to pharmaceutical and other cost increases plus increasing caseload. //2007//

/2008/ Legislative successes relating to child care subsidies, Early Head Start, and After school Programs funding were mentioned earlier. Other successes included expansion of the state's primary seat best law to teens. SB 211 allows officers to stop and ticket occupants ages 17 and under not wearing seat belts with an increase in the fine from $10 to $60. There is new funding of $200,000 for expansion of immunization outreach through the WIC clinics. The final budget included $800,000 start up funds for expansion of newborn screening. //2008//

/2009/ Internally, the State Agency uses an issue paper process to determine the importance, magnitude, value, and priority of competing factors impacting health services delivery including current and emergent issues. Bureaus within the division of health write issue papers relating to legislative and budget issues. These are reviewed by a group of peers and they are forwarded to a management team for review and prioritization. A final review by the Governor's team will determine which State Agency legislative and budgetary issues will be put forward in the next session. Policy issues that are of consequence only within the KDHE may be put forward at the same time. These may be considered and handled separately from those sent forward to the Governor.

Externally, Title V program staff engage in a number of stakeholder groups that put forward various agendas impacting the health care delivery environment. These are discussed in the coordination and collaboration section of this application. //2009//

/2010/ While the 2009 legislative session was almost totally focused on reductions to state agency expenditures, there were some bright spots. For instance, an estimated 8,000 more uninsured children will be eligible for health coverage under the SCHIP program based on legislation that passed during the session. HB 2354 extends eligibility for HealthWave, the children's health insurance program, to 250% of poverty. Another bill, HB 2143 protects youth. It implements for Kansas teenage drivers a graduated driver's license, multi-tiered program designed to ease young novice drivers into full driving privileges as they become more mature. In addition, the legislature renewed its commitment to keeping tobacco settlement dollars dedicated to children's initiatives including programs like MCH grants and newborn screening. //2010//

/2010/ H1N1 planning and response has been a major part of MCH/CSHCN efforts during the Spring of 2009. The state agency invested a great deal of public health manpower at both the state and local levels in responding to the virus.

On Friday, April 26, 2009 the Kansas Department of Health and Environment Laboratories received two specimens that were classified as unsubtypable Influenza A. After receiving confirmation from the CDC that the two specimens were in fact cases of the novel H1N1 virus, KDHE activated its Incident Command System (ICS). In order to manage the long hours required during the response, KDHE activated the KDHE Emergency Readiness Initiative (KERI), which garners volunteers from various departments within the agency to assist with the response. On Tuesday, April 28, 2009, Kansas received its first shipment of antivirals and Personal Protective Equipment (PPE) from the CDC. KDHE planners immediately began to working on a strategy to distribute the antivirals and PPE throughout the state. They were distributed state-wide the week of May 4, 2009 as cases of H1N1 continued to spread throughout Kansas.

KDHE response efforts include: regular disease surveillance and laboratory testing, community mitigation, communications and public information, and general emergency

response, including partnering with various local and state partners. In anticipation of an increase spread of H1N1 cases in Fall 2009, KDHE continues to maintain ICS, with the General and Command Staff meeting every other week to share any updates and progress. Current concerns related to H1N1 are the receipt of a large shipment of the H1N1 vaccine in the fall, adequate staffing to maintain the situation (especially in the laboratory), community mitigation to control the spread of disease, and communication strategies. As of July 14, 2009, Kansas has 169 confirmed cases of H1N1. Almost all staff in the bureau of family health but particularly the nursing staff have played major and minor roles in this effort. Staffs continue to cover phone banks, participate in community mitigation planning, coordinate with public and private providers, and plan for a Fall statewide vaccination program. //2010//

The 5-Year State Needs Assessment continues to guide Bureau decision-making for MCH and CSHCN. /2009/ More information about this process can be found in the needs assessment section of this application. //2009//

B. Agency Capacity

This section addresses the capacity of the Kansas MCH Title V Agency to promote and protect the health of all mothers and children, including CSHCN. It describes Kansas' capacity to provide essential public health services for pregnant women and infants, children and adolescents, and children with special health care needs.

Although the Kansas program has not completed a Capacity Assessment for State Title V (CAST-V) Programs, it has addressed core components. The program has established a vision, mission and goals for the maternal and child health population through a strategic planning process. Capacity assessment is a key part of the 5-Year MCH State Needs Assessment called MCH 2010 (www.kdheks/BFH). Through the Title V needs assessment process, Kansas has identified the priority health issues and desired population health outcomes for mothers and children. A review of the political, economic, and organizational environments for addressing the priority health issues was included in the needs assessment process. All relevant information was utilized to set strategic directions for the Title V program in terms of identification and implementation of organizational strategies to achieve the desired outcomes for the maternal and child health population.

Also, Kansas uses the ten essential public health services, the basis for the CAST-V assessment, to guide decision-making in all aspects of program operation. Following is an overview of Kansas' Title V capacity in relation to each of the ten essential maternal and child health services.

Essential Service #1. Assess and monitor maternal and child health status to identify and address problems. Kansas uses public health data sets to prepare basic descriptive analyses related to priority health issues. Data from the Behavior Risk Factor Surveillance System (BRFSS) that is conducted within the Office of Health Promotion is readily available and MCH has an opportunity each year to support additional modules relevant to emergent issues within MCH/CSHCN. Oral health and women's health modules have been supported in recent years. The Youth Risk Behavior Survey (YRBS) is conducted each year by the State department of education in partnership with local school districts. Previously, the data were not considered representative of the youth population due to non-participation of some school districts. Now, through the auspices of the CDC Coordinated School Health Program, the data will be representative and useful to the Title V program in tracking youth health behaviors.

/2009/ Vital statistics data of high quality are available, through an approval process, to the Title V program for assessment purposes. //2009// As of January 1, 2005, a new web-based electronic system is in place that implements the new national standards for vital records. /2008/ In 2007,

MCH received the first Vital Statistics data from the new system based on new NCHS standards. At this time, we are evaluating the impact of new categories on our trend data. In particular, entry into and adequacy of prenatal care and birth defects reporting categories appear to be affected. //2008// Additional new data elements will improve the ability of the MCH/CSHCN programs to assess birth/death and birth risk data. Other data sets maintained by other bureaus within the department that the Title V program uses for various analyses include immunization, cancer registry, child care licensing, STDs, HIV, State laboratory, primary care, farm worker health, trauma registry, as well as BFH program services data systems (WIC, MCH, CSHCN, Part C, Family Planning, Newborn Screening, Newborn Hearing Screening). /2009/ Use of these various data sets is outlined in various sections of this application. //2009//

Title V has access to data sets outside the BFH and the Department. Some examples of the type of data that are routinely accessed are Medicaid data (MMIS & Clearinghouse), hospital discharge data, department of transportation data (motor vehicle accidents), Kansas Bureau of Investigation (intentional injuries), department of social services, education department (school lunch program, school injuries). The annual MCH Block Grant submission includes a good representative sample of the types of data accessible to Title V. The State Systems Development Initiative (SSDI) grant provides a good overview of data quality and data linkage capacity.

MCH has shifted resources to two epidemiology positions for which orientation has been completed and training is ongoing. /2009/ One position is vacant as of this writing. //2009// The epidemiologists serve as data analysts and resource persons for MCH2010, the Kansas 5-year MCH State needs assessment, for the KDHE Healthy Kansans 2010, for the analysis of the National CSHCN Survey, National Child Health Survey, and birth defects data, and numerous other projects throughout the year. There is not sufficient capacity to conduct analyses of MCH data sets that go beyond descriptive statistics, although there has been some work in this area. The open mouth survey of Kansas third graders and the analysis of poison control center data are good examples of the latter. Increasingly, BFH epidemiologists and other staff have compared health status measures across populations. The Title V Information System (TVIS) on the Maternal and Child Health Bureau (MCHB) website is used often as a means of comparing health status measures for Kansas with those of other States. The State has very limited capacity to generate and analyze primary data to address State- and local-specific knowledge base gaps although there will need to be some work in this area particularly as this relates to CSHCN priority needs (medical home, youth transition, and financial access) since these will need information beyond that available from the National CSHCN Survey. /2009/ Annual surveys are used to assess school nursing capacity in the State. New surveys this year are the survey of WIC participants' food preferences and family satisfaction with CSHCN clinic services. Both the WIC survey and the CSHCN survey will be used to improve program services. //2009//

Primary and secondary data are routinely analyzed and used in policy and program development across all BFH programs but the quality and consistency of the analyses varies based on staffing considerations. MCH grants to local agencies require local needs assessment to set local priorities although capacity to provide training and technical assistance to the local agencies is limited. Local agency epidemiological capacity ranges from highly sophisticated, primarily in urban areas, to very unsophisticated, mostly the case in rural areas. Training of local staff to achieve consistency across all local agencies is needed. Training of State agency staff to achieve consistency across all BFH programs is needed as well. /2008/ One MCH epidemiologist received training in genetic epidemiology this year as part of the Sarah Lawrence College Public Health Genetics/Genomics certificate program. //2008//

Essential Service #2. Diagnose and investigate health problems and health hazards affecting women, children, and youth. BFH uses epidemiologic methods to respond to MCH issues and sentinel events. Recent examples of these activities are: the linkage of lead screening data with Medicaid EPSDT data; review of low birth weight data in response to legislative concerns; gastroschisis cluster study in response to physician concerns; review of lead screening data for

pregnant women in cooperation with the pediatric toxicologist at the Mid-America Poison Control Center and the perinatologist from the Kansas Perinatal Council. Through these and other efforts, the Title V program engages in collaborative investigations and monitoring of environmental hazards (e.g., State schools for the deaf and blind, juvenile correction facilities, birthing centers) to identify threats to maternal and child health. /2008/ The MCH epidemiologist is assisting in developing Agency policies and procedures for chronic disease cluster investigations, e.g., cancer. //2008//

/2007/ Last year, the Title V program was unsuccessful in its application to CDC for birth defects surveillance funds. The Title V program continues to seek federal funds to implement a law passed in the 2004 session giving the State agency statutory authority for a birth defects surveillance system. An analysis of the State's current activities in this surveillance area shows many gaps in meeting CDC standards for a birth defects surveillance system. //2007//

/2007/ Another interest for the Title V program is developing a prenatal surveillance system. This year, the Title V program was unsuccessful in its application to the CDC for PRAMS, Prenatal Risk Assessment Monitoring System funds. //2007//

Increasingly, the MCH epidemiologists serve as the State's expert resource for interpretation of data related to MCH issues. The Title V program is regularly consulted on MCH data issues and staffs participate as experts in planning processes requiring analyses. The agency provides leadership for reviews of fetal, infant, child, and maternal deaths through its work with the Kansas Perinatal Council. The program has limited contact with the State child death review board as the representative and information conduit is vital statistics. Through the MCH needs assessment process, Title V uses epidemiologic methods to forecast emerging MCH/CSHCN threats that are addressed through planning processes.

Essential Service #3. Inform and educate the public and families about maternal and child health issues. Title V has no health education plan per se and there are no Title V health education staffs per se. Health education functions are incorporated into the job duties of all Title V staff. There is no designated funding at the state level for health education activities, such as for print or media campaigns. Title V does not routinely assess priorities for health education services and appropriate audiences for those services. The exception to this is Healthy Start Home Visitor services. Home visitors provide individual-based health education for which there is a formal annual assessment. Visitors receive training in need/deficit areas. The oral health program is another exception. The oral health website has a wealth of information for parents and families, for providers and others on oral health. Health education is a significant part of the emergent Office of Oral Health. The CSHCN program incorporates transition information and education at specialty clinics. Grants to local organizations do not require particular individual-based health education activities. There is some general agreement that this area requires further review.

Even though there is no routine mechanism for identifying existing and emerging population-based health information needs, Title V has engaged in population based health information services, providing health information to broad audiences. There is no state or federal funding set aside for public awareness campaigns on specific MCH issues, so that foundation or other support is the usual source of financing for media campaigns. Title V collaborated with Kansas Action for Children on a statewide media campaign to raise public awareness about the importance of oral health for pregnant women and children. MCH partnered with the March of Dimes on a public health education campaign on the importance of folic acid usage. Nutrition and WIC services have expanded breastfeeding promotion and health education through all local health departments. Abstinence Education utilizes the services of a contractor to assist with its media campaign and health education activities. The CSHCN program is in the process of expanding the toll-free resources to the internet. Each of these activities was generated independently rather than in response to an overall review of state needs. With the addition of staff, the public information office of KDHE has new capacity to assist programs with websites, print materials, news releases, and other health education services. During the past year Title V

has received assistance in framing messages relating to MCH. /2009/ Through the auspices of the KDHE Office of Public Information, MCH has developed new print materials this year for birth defects surveillance and expansion of NBS (posters and pamphlets). //2009//

Essential Service #4. Mobilize community partnerships between policy makers, health care providers, families, the general public, and others to identify and solve maternal and child health problems. The Kansas Title V program is strong in this area, responding to community MCH concerns as they arise, regularly communicating with community organizations. Needs assessments and planning activities engage community audiences on state and local MCH status needs. The Title V program supports the office of health care information to produce issue- and population-specific reports that are distributed widely in the state. Informal mechanisms are utilized to obtain input into the Title V program on MCH/CSHCN needs. The 5-year state needs assessment process is a formal mechanism for obtaining community input into the program. Funding and technical assistance are provided to local providers for services that are determined locally through a community needs assessment process. No additional funding is available for local programs to establish community advisory boards but grants to community organizations such as the comprehensive school health services and disparity initiatives require local advisory boards and specify composition. Kansas Title V supports coalition and stakeholder groups primarily through technical assistance, although as in the case of the State Early Childhood Comprehensive Systems grant, funding may also be provided for planning activities. /2009/ For the implementation phase of SECCS, Title V has maintained both supportive and leadership roles. //2009// /2007/ MCH has been assigned responsibility for coordinating the Governor's Child Health Advisory Committee (CHAC) that has been charged with developing recommendations relating to immunizations, newborn screening expansion, school health education, and physical fitness/nutrition. Dr. Dennis Cooley Past President of the Kansas Chapter of the AAP has been appointed to head the group of 18 appointed individuals who are very broadly representative of the topical areas. //2007// /2008/ During the past year, CHAC has made recommendations to the KDHE Secretary relating to: 1) health care access for all children 0-18; 2) physical activity and nutrition to reduce obesity; and 3) expansion of the state newborn screening program. For more information go to: www.datacounts.net/CHAC. //2008// /2009/ Recommendations regarding breastfeeding support in the workplace and emergency medical services for children were completed during the past year. //2009//

Essential Service #5. Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth, and their families. Title V assembled a Panel of Experts for the five-year State MCH needs assessment, MCH 2010, played a major role in development of the State Early Childhood strategic plan, and participated in the Healthy Kansas 2010 process to determine priorities for the State agency. MCH/CSHCN routinely leads and/or participates in data-driven decision making and planning activities. The annual and five-year Title V grant application and needs assessment cycle serves as the cycle for systematic review of progress on objectives. Title V actively promotes the use of scientific knowledge bases in the development, evaluation, and allocation of resources for policies, services, and programs. A project underway for the MCH epidemiologists is production of a bi-annual MCH State Summary. The national and state performance measures will serve as the basis of the data in the report. The format for the annual publication, Reportable Diseases in Kansas, will be used to generate the MCH Annual Summary. /2007/ The report was published and disseminated in the summer of 2006. //2007// /2009/ The annual summary is almost complete for 2008. //2009//

MCH/CSHCN uses three formal advisory structures to advise Title V and KDHE: the Kansas Perinatal Council, the Kansas Child and Adolescent Health Council, and Families Together. Each of these groups holds quarterly meetings. Title V has input into the agendas to assure that key issues facing the State Title V agency are addressed. MCH epidemiologists are available to support the deliberations of the groups. Kansas Title V regularly utilizes data available within the department as well as data from other agencies and organizations (state, local and/or national) to inform State MCH health objectives and planning. These efforts are most evident in the annual

MCH Block Grant submission which utilizes a systematic process to produce an overview of the health of all mothers and children in the State. /2008/ In 2007, Judy Gallagher facilitated the Kansas Perinatal Council in developing a strategic plan. The group has decided to focus on expansion of Medicaid coverage to women of reproductive age. //2008//

MCH/CSHCN staffs are involved in multiple State-level advisory councils: Governor's Commission on Autism, Kansas Commission on Disability Concerns, Head Start, Kan-be-Healthy, Traumatic Brain Injury, Assistive Technology, and State Hunger Task Force. Routinely, staff partner with other agencies and programs as listed in the collaboration section of this application. Title V has a number of formal interagency agreements for collaborative roles such as the agreement for the Individuals with Disabilities Education Act (IDEA) programs of Part C (located in the State health agency) and Part B (located in the State education agency); agreement with KU's poison control center to assist in national certification efforts; SRS/KDHE interagency agreement primarily focusing on Medicaid and SCHIP collaborative efforts, among others. This latter agreement will need to be reassessed given the reorganization of the Medicaid and SCHIP programs to a newly established State agency that is described in the State Overview section. This will likely be done after the July 1, 2006 final reorganization. /2009/ This has not yet been completed. //2009// The Title V program has contributed to the planning processes of several State initiatives and implementation of a joint State initiative. Routinely, Title V staff are consulted by others needing guidance on MCH population services. Over time there has been a pattern of a gradual shift towards other programs developing independent capacity to address traditional MCH (BFH) issues. Two examples of this shift are as follows: hiring of a staff person within the Bioterrorism program to address MCH issues and development of programs to address needs of school aged population by chronic disease through the CDC Coordinated School Health grant. Still, the BFH serves as the representative of the State health agency at key meetings such as public/legislative hearings relating to MCH/CSHCN issues.

Essential Service #6. Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being. BFH has the responsibility for assuring legislative and regulatory adequacy for MCH/CSHCN. Title V has not coordinated a formal review of adequacy and consistencies of legislative/regulatory mandates across all programs serving MCH populations for a number of years. There have been a number of reviews of specific legislation or regulations due to emergent policy or program issues. Recently, Title V participated with child care licensing and the Kansas Perinatal Council in a review of outdated birthing center regulations. KPC recommended that the State adopt national standards for birthing centers. /2007/ This year, newborn screening statutes and regulations were updated relating to treatment formula.//2007//

Title V staff routinely attend legislative hearings related to maternal and child health issues and provide testimony. Examples of these activities are hearings on fluoride in public drinking water and impact on the oral health of children, and the importance of community/workplace support for breastfeeding. /2007/ In the 2006 Legislature, a law was passed supporting a women's right to breastfeed in a public place and granting deferrals from jury duty for breastfeeding women. //2007// The Title V program engages in strategies for informing elected officials about legislative/regulatory needs for maternal and child health such as when the oral health survey report was provided to legislators and others in policy making positions to fill knowledge gaps relating to the oral health of Kansas children. As part of the KDHE budgetary process, BFH puts forward proposals for legislation, budgetary or regulatory changes each summer. Proposals are reviewed by an internal executive team and prioritized in terms of the overall needs of the agency. The budget is submitted to the Governor in early Fall.

Title V staff are encouraged to participate in professional organizations and to engage with other State agencies in the development of licensure/certification processes. Kansas Public Health Association and Kansas State Nurses Association are examples of participation. Title V provides leadership to the development of quality standards of care for women, infants and children in collaboration with other agencies and organizations such as Medicaid's EPSDT Advisory Board,

Hearing Screening Guidelines and Vision Screening Guidelines. See birthing center regulations as in #5 above. Specialty clinic standards are another standard setting activity. The Title V program has collaborated with Medicaid and SCHIP to incorporate MCH standards and outcomes such as the low birth weight Pregnancy Improvement Project with First Guard, adoption of the CSHCN definition in managed care contracts, and use of the CSHCN program for consultation regarding care. MCH promotes Bright Futures as the standard for local MCH agencies throughout the State. MCH routinely conducts record and site reviews of local agencies and allocates staff resources to provide technical assistance. The MCH aid to local program has initiated a risk-based schedule for reviews of local agencies to improve allocation of technical assistance. /2007/ During the past year, MCH/CSHCN staff have been involved in policy and legislative issues relating to child passenger safety seats, child care health consultation, birthing center regulations, regulations relating to community-based and faith-based organizations that serve pregnant women through "Pregnancy Maintenance Initiative" State dollars. //2007//

Essential Service #7. Link women, children and youth to health and other community and family services and assure quality systems of care. The Kansas Title V program develops, publicizes and routinely updates its Make a Difference Information Network (MADIN) toll-free line. There are plans to use website, TV, radio, and print advertisements to publicize the line. At all points of contact with women, children, and families the Title V program provides verbal information and/or print materials about publicly funded health services (e.g., family planning, WIC sites). The Title V program assists localities in developing and disseminating information and promoting awareness about local health services through such activities as community resource and referral lists that are maintained at each local service site. There has been no systematic effort to evaluate the effectiveness and appropriateness of efforts to link women and children with services.

Kansas Title V coordinates with managed care organizations (MCOs) on outreach and home visiting services for hard to reach populations. Innovative methods of providing services such as one stop shopping in Wyandotte County and CSHCN involvement in Juniper Gardens have been encouraged although there has been no funding for these efforts. Technical assistance is provided at conferences and at on-site visits to local agencies, also to providers in identifying and serving hard-to-reach populations. BFH disseminates information on best practices to local agencies, providers, and health plans across the State.

Tracking systems for universal, high risk and underserved populations are developed and routinely evaluated such as the evaluation of newborn metabolic screening and follow-up system in preparation for the application to CDC for birth defects surveillance system funding. In collaboration with partners, CSHCN is implementing new outreach through vital records data. Program information and brochures will be mailed to parents of children with high risk conditions noted on the birth certificate. MCH and CSHCN provide or pay for direct services not otherwise available. Examples of these services are: child health assessments for school entry through local health departments for uninsured and underinsured children; and CSHCN medical specialty clinic services.

Resources are provided to strengthen the cultural and linguistic competence of providers and to enhance their accessibility and effectiveness. CSHCN and other staff routinely authorize interpreters at out-patient appointments for families who have English as a second language and phone for assistance. Interpretation services are available within KDHE through the public information office and the farm worker health program. All BFH staff has participated in cultural competency training as well as continuing education opportunities as these are available. The Title V program assures that local health departments and other local agencies interface with culturally representative community groups and prepare outreach materials and media messages targeted to specific groups. When there are vacant positions, there has been an effort within the BFH to recruit persons of color and bilingual staff in partnership with Human Resources.

This year, monthly meetings with Medicaid staff were suspended following the exit of one key

individual. Proposals for Medicaid waivers and other collaborative activities were dropped as Medicaid staff were shifted to new responsibilities and inundated with legislative inquiries about a proposed major State reorganization. /2007/ despite a number of challenges to MCH-Medicaid collaboration due to reorganization, the staffs of Medicaid and MCH continue a close working relationship. //2007// /2009/ Working relationships with Medicaid are back on track following the reorganization, although the update of the Title V/Title XIX Interagency Agreement has not been accomplished. //2009// Staff meets with foundations, professional organizations and other potential partners regarding established and new ventures. Interagency agreements are routinely reviewed for effectiveness and appropriateness. Kansas works with the Medicaid agency and Insurance Commission as appropriate on enrollment screening procedures, tracking of new enrollees' utilization of services and consumer information.

MCH/CSHCN provides leadership and resources for a statewide system of case management and coordination of services by convening community providers and health plan administrators to develop model programs and linkages. The Title V program distributes best practices information throughout the State via its website, at conferences, and through program-specific training. Kansas provides leadership and oversight for systems of risk-appropriate perinatal and children's care and care for CSHCN including: cross-agency review teams; developing and monitoring risk-appropriate standards of care; and, routine evaluation of systems.

Essential Service #8. Assure the capacity and competency of the public health and personal health work force to effectively address maternal and child health needs. A link between the Title V program, the school of public health, and other professional schools to enhance state and local analytic capacity has not been established. Internship/practicum students have not been used to any great extent. /2009/ An intern was secured this year to assist with development of Child Care Health Consultation training for Healthy Start Home Visitors. Also, the intern assisted Child Care Licensing with update of health and immunization forms for child care providers. //2009// Academic partnerships, joint appointments, adjunct appointments, MOUs with academia, and sabbatical placements have likewise not been considered. Title V staff occasionally guest lecture at professional schools in the State such as the school of social welfare and the public health certificate program. MCH/CSHCN collaborates with the primary care program to monitor changes in the public health workforce. Resource inventories of facilities and programs are also available through this source. Geographic coverage and availability of services and providers are continually monitored. The 5-year State needs assessment addresses workforce issues and workforce gaps are considered in overall program planning. Examples of activities to address workforce shortages include: Title V coordination with Medicaid, the Kansas School Nurse Organization, the Kansas Association of Local Health Departments, and others to assure statewide fluoride varnish training for nurses. Another example is BFH coordination with Head Start, Early Head Start and other early childhood providers to adopt a quality curriculum for home visitors in the State and assure consistent training for home visitors across all programs.

Kansas MCH/CSHCN builds the competency of its workforce through support for continuing professional education for staff. All staff maintain an Individual Professional Development Plan (IPDP). They participate in orientation and training and in ongoing in-service education. Title V staff are encouraged to log on to mchcom.com archived materials to obtain information on emergent issues. Staff participate in Leadership Conferences, the annual AMCHP meeting, and other in-state and out-of-state education opportunities. BFH in-service meetings are held on the first Monday of each month. Topics and speakers are drawn from suggestions of participants. All BFH supervisors collaborate with State human resources office in establishing job competencies and qualifications. If relevant, Title V includes job qualifications in contract requirements with local agencies as, for instance, in requiring multidisciplinary teams for prenatal care coordination services, or nursing/social work services for case managers. /2008/ In Spring of 2007, the Governor's Public Health Conference had a specific MCH focus and preconception health was a featured topic. //2008//

Essential Service #9. Evaluate the effectiveness, accessibility and quality of personal health and

population-based maternal and child health services. Routine monitoring is assured for all MCH/CSHCN state-funded services. Neither MCH nor CSHCN has routinely evaluated outcomes of the services provided. All Title V issued grants require that projects will participate in routine monitoring. All require reporting submission of qualitative and quantitative data. Some but not all require submission of an evaluation plan. For others such as teen pregnancy prevention, a contract is secured with an outside evaluator as from academia. Technical assistance may be provided to local agencies to design, analyze, and interpret their data depending on the program. State data is available to local agencies to facilitate implementation of their community assessments and evaluations through Kansas Information for Communities and other data sources. This year as part of an evaluation process, the BFH organized a review of lead screens completed during the EPSDT visit for children participating in the State Early Head Start program.

Consumer satisfaction is routinely assessed for all programs. Various mechanisms are used to assess satisfaction including mail-in postcards provided at the time of the service, phone surveys, family advocacy feedback, and focus groups. The Families Together contract includes a requirement for assessment of client satisfaction with services. BFH performs comparative analyses of programs and services when data are available across different populations or service arrangements such as for family planning or WIC. /2009/ In 2007 and again in 2008, special satisfaction surveys have been conducted with families participating in CSHCN and attending CSHCN clinics. The results of surveys are used by staff to improve clinic services, especially family satisfaction with services. //2009//

As requested, the results of monitoring and evaluation activities are reported to program managers, policy makers, communities and families/consumers. When there are deficiencies, corrective action is taken. The Title V program disseminates relevant State and national data on "best practices." MCH plans quality improvement activities and communicates these to local agencies and other groups as needed. Information from evaluation and quality improvement activities does not necessarily translate into programs and practices. Interest groups outside the Title V agency are more likely to influence program and policy development. Thus, there is a need for stakeholder involvement in all phases of planning, program development, operation and evaluation.

The Title V program has not identified a core set of indicators for monitoring outcomes of private providers and is not "at the table" in discussions with insurance agencies, provider plans, and others about the use of MCH outcomes in their own assessment tools. /2009/ An exception to this is the SECCS plan. MCH his still at the table with early childhood providers and advocates. In late 2008, an invitation-only retreat will be held to examine and refine the early childhood indicators for the State. A set of key indicators will be developed that are more in line with those recommended by national groups such as Project Thrive. //2009//

Essential Service #10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health related problems. The MCH program disseminates ZIPS, a monthly newsletter which abstracts current MCH research and reports to the readership. BFH staffs engage in research on a limited basis. When research is undertaken, it is widely disseminated upon completion. The BFH and KDHE are highly regarded for the availability of high quality data regarding many diverse health-related issues. Only very limited staffing resources are available for research, for local demonstration projects and special studies. Much of the research work is of a collaborative nature and done in consultation with our staff rather than directed by our staff. For instance, BFH is collaborating with the Bureau of Epidemiology and Disease Prevention in a research project to determine immunization status of pregnant women.

C. Organizational Structure

The Secretary of the Kansas Department of Health and Environment (KDHE) is appointed by the Governor and serves on the Governor's Cabinet. The Secretary reports directly to the Governor. Prior to the Spring of 2005, there were four divisions under the KDHE Secretary: Health, Environment, State Laboratory, and Center for Health & Environmental Statistics. A reorganization in 2004 consolidated these to three divisions. The Center for Health and Environmental Statistics was moved under the Division of Health so that the Center Director reports to the Director of Health. /2009/ Another reorganization consolidated the State Public Health Laboratory under the Division of Environment. //2009// The Director of Health serves as the State Health Officer. ***/2010/ Dr. Jason Eberhart-Phillips has held this position since February of 2009. He came to us from California where he managed a large county health department. His previous experience is broad and includes chronic disease, epidemiology at national, state and local levels. His broad public health experience makes him well-suited for his work at KDHE. His CV is included as an attachment. //2010//***

The Division of Health has five Bureaus: Bureau of Family Health (maternal and child health); Bureau of Child Care Licensing and Health Facilities (child care & hospital regulation, credentialing); Bureau of Consumer Health (lead program; food service inspections); Bureau of Epidemiology and Disease Prevention (infectious disease, bioterrorism); and the Bureau for Health and Environmental Statistics. There are three Offices: Office of Local and Rural Health (manpower, primary care, migrant health, hospital bioterrorism); Office of Health Promotion (chronic disease); and Office of Oral Health. An effort is underway to establish a fourth Office of Minority Health. /2007/ This Office was formally established in 2006. //2007// /2009/ In 2008, a legislative initiative moved restaurant and food service inspections to the Department of Agriculture. //2009// ***/2010/ There is discussion within the department to create another bureau, the Bureau of Environmental Health. This bureau would include lead screening and lead abatement programs with funding through the EPA. It has not been decided where the new bureau will reside, the Division of Health or the Division of Environment. //2010//***

The Bureau for Children, Youth and Families (BCYF) now the Bureau of Family Health (BFH) administers the MCH Services Block Grant. It has four sections: Nutrition and WIC Services; Children's Developmental Services, Children and Families Services; and Children with Special Health Care Needs. The organization chart for the BFH and the four sections is attached as a PDF file. Also, refer to the BFH organizational structure and staffing on the BFH website at www.kdhe.state.ks.us/bcyf. /2008/ The Bureau for Children, Youth and Families was officially renamed the Bureau of Family Health in the Spring of 2007. //2008// ***/2010/ The Children with Special Health Care Needs section has been renamed to the Children & Youth with Special Health Care Needs section. This will take into account growing activity in the area of youth transition. //2010//***

Within the Bureau there are a number of cross-cutting initiatives such as oral health and epidemiology. In April, 2002, the BFH hired a registered dental hygienist to build oral health capacity in the agency, to integrate oral health education and health promotion into all maternal and child health programs and to serve as an agency link with emergent oral health coalition efforts in the state. This position has since been integrated as Deputy Director into the new Office of Oral Health. Recruitment of a Director (dentist) is underway. /2007/ A Director was hired in 2006. //2007// The Deputy Director continues to provide consultation, technical assistance, assessment (oral health survey), policy development (coalition-building), and assurance (fluoride varnish training). She serves as consultant to all Bureau programs including MCH/CSHCN and WIC. The Bureau has two epidemiologists that serve as consultants to all programs. They interface with epidemiological work done in other Bureaus inside the agency and with other organizations and efforts in the state. One epidemiologist serves as the State Systems Development Initiative project coordinator. Both epidemiologists coordinate all data analyses for the MCH/CSHCN needs assessment with Envisage Consulting. Both conduct assessments and evaluations of MCH programs, conduct original MCH research, and address epidemiologic needs

of the Bureau. Each of the Sections is attempting to build data capacity through staff training and education and rewrite of job descriptions to require data skills for newly hired employees.

The Children & Families Section includes the following responsibilities: 1) Systems development activities for perinatal systems of care including coordination with Perinatal Association of Kansas; 2) Systems development for child, school and adolescent health care, in partnership with the Kansas Chapter of the American Academy of Pediatrics, Kansas School Nurse Association and others; 3) Maternal and Child Health grants to assist local communities to improve health outcomes for pregnant women and infants and for children and adolescents; 4) Women's Health Care and Family Planning - Systems of care and grants to communities to support the health of women in their reproductive years; 5) Other grants targeted to specific populations and needs - teen pregnancy prevention; adolescent health disparities; abstinence education, comprehensive school health clinics.

Children with Special Health Care Needs assumes the following responsibilities: 1) Systems development activities - promotes the functional skills of young persons in Kansas who have a disability or chronic disease by providing or supporting a system of specialty care for children and families including specialized services and service coordination, quality assurance, and community field offices; 2) Make a Difference Information Network (MADIN) - Assists children and adults including those with disabilities, their families and service providers to access information and obtain appropriate resources. MADIN serves as the MCH toll-free line.

The Children's Developmental Services Section includes the following programs: 1) Infant-Toddler Services (Part C of IDEA) - Promotes the early identification of developmental delay and disorders through child find, services coordination (case management), resource referral and development, and direct service provision for eligible infants and toddlers and their families; 2) Newborn Metabolic Screening - Assures early identification and intervention for infants with PKU, galactosemia, hypothyroidism and sickle cell; 3) Newborn Hearing Screening - Assures early identification of significant hearing loss in newborn infants. /2007/ NBHS includes follow-up and interventions. Starting in SFY 07, $50,000 was appropriated for a hearing aid loaner program for young children. //2007// /2008/ A proposal to move the Infant-Toddler program to another State Agency (SRS) was put on hold pending creation of an Office of Early Childhood. Two additional staff will be hired for this Section in mid-2007 to begin start-up work on expanded newborn screening. //2008// /2009/ The proposal to move the Infant-Toddler program to another State Agency (SRS) is still on hold pending review of the creation of a State Office of Early Childhood. Two additional staff were hired this year to support the expansion of newborn metabolic screening program. As well, newborn metabolic screening and newborn hearing screening staffs were merged to form the Newborn Screening Unit within the CDS. //2009//

Federal law requires that Part C (KDHE) and Part B of IDEA (State Education Agency) maintain an advisory committee. The Kansas Coordinating Council on Early Childhood Developmental Services serves in this capacity and the staffers for this council have their offices in the BFH. Members are parents of children with special needs, legislators, early intervention service providers, state agencies, and community members.

The Nutrition and WIC Services Section includes the following programs: 1) Nutrition Services - Improves the health and nutritional well being of Kansans through access to quality nutrition intervention services including educational materials, consultation services, program coordination and referrals; 2) the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) - Provides nutrition education, breast-feeding promotion and support, substance abuse education, nutritious supplemental foods, and integration with and referral to other health and social services; 3) Commodity Supplemental Food Program (CSFP) - Improves the nutritional status of eligible women, infants, children, and the elderly over age 60 through supplemental foods and nutrition education. /2007/ WIC completed the transfer of the CSFP program to the Kansas Department of Social and Rehabilitation Services (SRS). This had been initiated a couple of years ago due to a change in the service population from pregnant women and children

to the elderly. //2007// ***/2010/ In addition to a special breastfeeding peer education and support program, WIC helps to coordinate the State Breastfeeding Coalition whose current mission is support and promotion of breastfeeding in the workplace. //2010//***

The State health agency is responsible for the administration (or supervision of the administration) of programs carried out with allotments under Title V [Section 509(b)]. When funds are allocated to other programs outside the BFH, the Bureau maintains legal contracts for the use of the funds, or in the case of funds allocated to other programs within the KDHE MOUs clarify the nature of the work that is done in support of the MCH priorities. All programs funded by the Federal-State Block Grant Partnership budget total (Form 2, Line 8) are included.

Official and dated organizational charts that include all elements of the Title V Program, clearly depicted, are on file in the State Human Resources office and are available upon request at the time of the Block Grant Review. Also, please see attachments.

/2010/ A fiscal reorganization that is effective July 1, 2009, will centralize all purchasing, ordering, and travel vouchers in the agency under the Purchasing Director for the department. All fiscal matters in the department will be centralized with staff outstationed in the bureaus. No doubt this is in response to the tight fiscal situation for the agency and the state. At this time all fiscal work in the agency is completed through a centralized process. //2010//

An attachment is included in this section.

D. Other MCH Capacity

The BFH has 57 full-time equivalent (FTEs) positions: 5 FTEs including 2 epidemiologists are located in administration, 10 FTEs in CSHCN Section, 12 FTEs in Children & Families Section, 15 FTEs in Children's Developmental Services, and 15 FTEs in WIC. None of these positions are out-stationed in local or regional offices. The MCH Block Grant is used for 21.25 FTEs or 40% of the staffing in the Bureau. This breaks out to 3.75 FTEs in Administration, 10.0 FTEs in CSHCN, 7.0 FTEs in C&F Section, 3.0 in CDS, and 0.25 in WIC. /2007/ Four new FTEs were obtained in the 2006 session including a genetics counselor and health educator to implement provisions of a cord blood bank bill. //2007// All non-clerical staff position descriptions have been re-written to require planning, evaluation and data analysis capabilities. The qualifications, in terms of a brief biography, of senior level management employees in lead positions are as follows. /2009/ Prior to the 2008 session, the BFH received two new positions for newborn screening follow-up. These positions have been filled. In addition, another vacancy in the bureau was allocated to meet the staffing requirements of the expansion. //2009//

Since 2000, Linda Kenney has served as Director of the Bureau and Kansas Title V Director. From 1989-2000 she served as Director of the Children and Families Section in the Bureau, primarily responsible for services to pregnant women and infants, children and adolescents, and women's health. She has held positions as director of a state breast and cervical cancer screening program, director of a state mental hospital-community transition project, case management supervisor for a community disability organization, and director of a local family planning clinic. She has served on the Board of the Kansas Public Health Association (KPHA), and on a number of state and federal advisory groups relating to maternal and child health. She holds an MPH degree in Health Services Administration from the University of Pittsburgh, Pennsylvania and a bachelor's degree from Indiana University. In addition to the four Section Directors, four other staff report to her (2 epidemiologists, dental hygienist (transitioning to Office of Oral Health), 1 fiscal, 1 clerical). /2009/ The establishment of the Office of Oral Health is complete and the dental hygienist has moved to that Office. //2009//

/2010/ Marc Shiff serves as the State CYSHCN Director. He has a Master's of Public

Administration degree from the University of Texas at Dallas with concentrations in Health and Education. His Bachelor of Science degree in Management and Social Science is also from the University of Texas at Dallas. Prior to his current position, he served as Director of Operations and Services for the KDHE Bureau of Disease Control and Prevention and as Programs Manager for the University of Kansas Medical Center, Kansas City, providing medical and nursing continuing education oversight. He was appointed to the Governor's Commission on Autism Task Force, and is a member of the Kansas Department of Social and Rehabilitation Services Traumatic Brain Injury advisory board, Kansas Families Together Advisory Council, and past Co-Chair of the Kansas Community Planning Group. Seven CYSHCN Topeka staff report to him and he provides CYSHCN program support and guidance to 6 field contractors in Kansas City and Wichita. //2010//

Ileen Meyer is a professional registered nurse experienced in serving the pediatric and young adult population throughout her 35 year career in public health. Along with her nursing background she holds a Master of Science degree in Counseling Education from Emporia State University. She has extensive experience working with adolescent health and education issues. She joined KDHE as the Director of Children & Families Section in 2000. She is involved with the Kansas Chapter of the American Academy of Pediatrics and its specialty subcommittees, Kansas Perinatal Council, Kansas Suicide Prevention Steering Committee, Early Childhood Stakeholders Advisory Committee, Head Start Collaborative Stakeholders, Kansas Safe Kids Coalition, Kansas Action for Children, Kansas Fatherhood Coalition, and Kansas Works Interagency Coordinating Council. Meyer manages a staff of 11 FTEs (4 nurses, 4 program planning and evaluation, 1 data entry and 2 clerical).

Carolyn Nelson has served as the Director of Children's Developmental Services since 2001. From 1999 to 2001, she coordinated services for the Infant-Toddler (Part C) Program at KDHE. Prior to 1999, she worked as Director of Children's Developmental Services at Arrowhead West, Inc. in Southwest Kansas and as a speech-language pathologist in Arkansas. Carolyn holds a degree in Speech-Language Communication and English from Henderson State University in Arkansas. She represents KDHE on the Kansas Division of Early Childhood Board and the Kansas Coordinating Council on Early Childhood Developmental Services. She is also involved in the Head Start Collaboration Council and Advisory Board, Early Childhood Stakeholders, the National Part C Coordinators' Association, School Readiness Task Force, Child Care and Early Education Advisory Committee, and the National Council for Exceptional Children. Nelson manages a staff of 14 (2 nurses for newborn screening, 1 medical technologist, 2 audiologists for newborn hearing screening, 1 early childhood, 1 fiscal, 4 program planning and evaluation, 3 clerical).

David Thomason is the Director of Nutrition and WIC services. He has served in that capacity since 1998. From 1989 to 1998, he managed fiscal services and reimbursement in the Kansas Medicaid Program. David holds a Master's degree in Public Administration from the University of Kansas and a Bachelor of Science degree in Human Service Agency Management from Missouri Valley College. The WIC program implemented an automated WIC system for Kansas. The new WIC system will allow local agency staff to spend more time on mission oriented educational activities and less time on administrative duties. Thomason manages a staff of 14 FTEs (4 nutritionists, 2 information systems, 4 program analysts, 4 clerical).

The one change to leadership within the BFH (the CSHCN Director) has been noted above. BFH staff have been appointed to a number of Governor's Initiatives: State Hunger Team, Blue Ribbon Task Force on Immunization, Bioterrorism Coordinating Council, and State Developmental Disabilities Council. Both Carolyn Nelson and David Thomason have completed the Kansas Public Health Certificate Program. /2007/ David Thomason was elected as Vice President of National Association of WIC Directors (NAWD). //2007// /2008/ He served a term as NAWD President this year. //2008//

An attachment is included in this section.

E. State Agency Coordination

Coordination within the State Health Agency

MCH and CSHCN work with a number of program areas on public health issues. Office of Local and Rural Health: Primary Care Cooperative Agreement; District Nursing Consultants; Community Health Assessment Coordination; Farmworker Health; Refugee Health; Trauma Registry; Bioterrorism Hospital Preparedness. Bureau of Child Care Licensing: standards for health and safety in out of home care; inspections of residential facilities; inspections for state schools for deaf and blind; inspections of birthing centers. Bureau of Consumer Health: Childhood Lead Poisoning and Prevention. Bureau of Health Promotion: Breast & Cervical Cancer Screening Program; Office of Injury/Disability Program; Youth Tobacco Prevention Program; Diabetes Control Program; Kansas LEAN Program; Arthritis Program; 5 A Day; Kansas LEAN 21. Bureau of Epidemiology and Disease Prevention: HIV/STDs Program; and Immunization Program.

Division of Health and Environmental Laboratories: Inorganic Chemistry (Lead Screening); Neonatal Metabolic Screening. Center for Health and Environmental Statistics, Vital Statistics: Perinatal Outcome Data, Adequacy of Prenatal Care Utilization Index (APNCU); hospital discharge data, and data linkages with Medicaid.

Coordination with Other State Agencies

Education and Social Services are the two State Human Services Agencies with whom MCH/CSHCN frequently has contact. MCH works with the State Department of Education on health related issues for preschool and school-age children including guidance for school nurses and administrators (see the BCYF website --- http://www.kdhe.state.ks.us/bcyf/c-f/school_resources_docs.html). There are ongoing efforts to expand the school nurse role to include preventive and primary health care at school for children and youth who are at risk including the underinsured and uninsured school population. Delegation of nursing tasks to unlicensed school personnel is an ongoing issue. Title V staff assist the State Education agency and Kansas Board of Nursing with this issue. Title V staff serves on the Statewide Education Advisory Council and attends the special education administration staff meetings. This collaboration has served to strengthen the health services components for special health care needs students in local school districts.

The federal legislation on inclusion has necessitated the reeducation of school nurses and training for allied school personnel in the provision of care to medically complex children. "Guidelines for Serving Students with Special Needs Part II: Specialized Nursing Procedures," helps local education agencies provide services to CSHCN students. This was a collaborative project between Title V and the State Department of Education. Standards for CSHCN are also underway for early childhood education programs and child care providers. Others areas of significant collaborative efforts include: Part B of IDEA, School Readiness, and School Nutrition.

Schools, health departments, and primary care providers are encouraged to use "School Nursing and Integrated Child Health Services: A Planning and Resource Guide" in tandem with Bright Futures as the standard for provision of public health services to children. Multiple professional development opportunities are provided utilizing the statewide Area Health Education Centers (AHECs) and local area education service centers as training sites. It is anticipated that a day long video conferencing format will become the norm with facilitators available at times and sites convenient for any school district.

The Social Service Agency (SRS) programs with which MCH/CSHCN has most frequent contact are Medicaid and SCHIP (HealthWave). MCH/CSHCN assists with outreach and enrollment efforts, reviews data relating to utilization patterns, assists with provider recruitment, promotes

standards of care, assures provider training, among others. Local MCH agency dollars expended on Maternal and Child Health services are utilized as match for federal Medicaid dollars to provide prenatal case management, nutrition and social work service for high risk women as well as newborn postpartum home visits. These and other collaborative arrangements are formalized in the KDHE/SRS Interagency Agreement (updated in 2002 to include HIPAA and data sharing). MCH/CSHCN staff meet monthly with Medicaid and HealthWave staff to discuss mutual concerns and to plan for identified service needs. Medicaid includes information about the WIC program in its notices to clients reminding them of immunizations due. Currently Medicaid and Family Planning are working on a waiver to extend the mother's eligibility after birth from 6 weeks to 2-5 years. /2007/ This effort has been postponed due to reorganization within the Medicaid state agency. //2007//

MCH/Infant-Toddler Services staff, in collaboration with Medicaid staff, have developed a Medicaid reimbursement fee for a service system of early intervention services (such as occupational therapy, physical therapy and speech-language therapy) through a specially designed Infant-Toddler early intervention Medicaid providership. Training was provided to teach the Infant-Toddler Networks how to use their providership numbers to bill for these services. In 1999, the Infant-Toddler Services Medicaid providership was enhanced to include targeted case management (service coordination) as a reimbursable service for eligible infants and toddlers. Preliminary steps were implemented to add developmental intervention services as a Medicaid reimbursable service which was added in 2002.

For the high-cost services for special needs children, the interagency agreement directs mutual referrals, cross program education, fiscal responsibilities and case management services for children participating in both Medicaid and CSHCN programs. Title V implemented linkages with the Medicaid and EDS/MMIS System so that CSHCN staff have direct access to Medicaid information on children eligible for both Title V and Title XIX/XXI.

An interagency agreement delineates mutual responsibilities between Title V and SRS focusing on referral of Supplemental Security Income (SSI) children and youth between the two agencies. A third party, the Developmental Disabilities Center assists in design of materials to improve reporting of reliable information to make an accurate determination of eligibility for SSI benefits, and recruitment and expansion of the SSI provider pool for SSI consultative examinations. Another development is training for providers who give consultative evaluations. CSHCN staff have a B agreement in place that allows increased access to SSA data.

Through the Farmworker Health Program and with Medicaid coordination (described in the interagency agreement), children and families of migrant and seasonal farm workers receive primary, preventive, acute and chronic care services at seventy-five clinic sites. Title V staff coordinate with Farmworker Health staff in the Office of Local and Rural Health to identify methods to maximize use of individual program funds to assure access to prenatal care and specialty care/follow up for farmworkers and their families.

Title V works with Employment Preparation Services in SRS on issues such as teen pregnancy prevention and public health assistance for indigents. Title V has worked with Alcohol and Drug Abuse Services on a number of substance abuse issues including prevention programs for youth, identification and intervention for pregnant women, and treatment facility standards for pregnant substance abusers. Title V has worked with Mental Health on a state plan for adolescent health, youth suicide and other issues. MCH serves on the State Developmental Disabilities Council located in SRS. KDHE's Child Care Licensing works with Foster Care regarding quality of child placements. CSHCN works with Rehabilitation Services (Vocational Rehabilitation), Disabilities Determination and Referral Services.

Other State agencies with whom MCH/CSHCN collaborates include the following: Kansas Department of Insurance on issues of public and private insurance coverage for the maternal and child population. MCH works with the Kansas Department of Transportation (KDOT) and the

Kansas Board of Emergency Medical Services through the Injury Prevention program on data and policy issues. MCH/CSHCN have participated with the Kansas Advisory Committee on Hispanic Affairs and the Kansas African American Affairs Commission on cultural and linguistic competence issues. The Kansas Advisory Committee on Hispanic Affairs provides assistance with finding translators. MCH has assisted the Kansas Department of Corrections on health standards for youth facilities, finding providers of prenatal care for pregnant inmates.

Coordination with Other Agencies and Organizations

University and other collaborations are as follows: University of Kansas; Bureau of Child Research/Center for Independent Living; Life Span Institute; University Affiliated Programs, Kansas University Center for Developmental Disabilities, Lawrence and Parsons; Developmental Disability Center/LEND Program; School of Medicine; School of Social Welfare; Preventive Medicine; Mid-America Poison Control Center; Area Health Education Center; Wichita State University; Kansas State University; Cooperative Extension Kansas Nutrition Network; University of Kansas School of Medicine - Wichita, MPH Program; Heartland Regional Genetics Consortium (to develop State genetics plan).

MCH works with professional groups, private non-profit organizations and others such as the following: March of Dimes; American Academy of Pediatrics - Kansas Chapter; Kansas Children's Service League; Children's Coalition; Kansas Adolescent Health Alliance; Dietetic Association of Kansas; Kansas Action for Children; Families Together, Inc; Kansas Hospital Association; Assistive Technology Project of Kansas; Kansas Medical Society; Kansas Lung Association; SAFE Kids Coalition; Kansas Immunization Action Coalition; Kansas Health Foundation (KHF); Sunflower Foundation; Kansas Health Institute; Kansas Public Health Association; Perinatal Association of Kansas; SIDS Network of Kansas; Mexican American Ministries; Campaign to End Childhood Hunger; United Way; Kansas Head Start Association; Kansas Nutrition Council; Kansas Dental Association; Kansas Association of Dental Hygienists; United Methodist Health Ministries; Fetal Alcohol Syndrome pilot project; National School Readiness Indicators Workgroup; Kansas Head Start Collaboration Project.

There is an interdependent relationship between the State and local public health agencies. Kansas' 99 local health departments (LHDs) serve all 105 counties. The local health departments are organized under city and/or county government. They are mostly reliant on county mill levy funding, although some modest per capita state formula funds are provided to each county. Contracts and grants from the state health agency provide a third significant source of funding. The staffer for the Kansas Association of Local Health Departments assures coordination with KDHE. LHD representatives serve on all KDHE workgroups and committees with potential impact on LHDs.

MCH Block Grant dollars support regional public health nurse activities such as: regional public health meetings which serve as a forum for updates; technical assistance to local health departments regarding administrative issues, including billing, grant writing, budget, human resources, information systems, policy/procedures, HIPAA; technical assistance to local health departments regarding public health practice issues, including public health performance standards and competencies, as well as the MCH Pyramid of Core Public Health Services; collaboration with Heartland Center for Public Health Preparedness and University of Kansas School of Medicine, Department of Preventive Medicine and Public Health, for training sessions on cultural competency and diversity, risk communication, informatics, and public health law, through Kansas Public Health Grand Rounds series; distribution of resource publications and information necessary to support practice, including Connections Newsletter, Kansas Rural Health Information Service (KRHIS), OLRH website, Public Health Nursing and Administrative Resources Manual, and Domestic Violence Manual. Public health nurses maintain ongoing partnerships to support education/training for public health with state and regional training partners, including: Heartland Center for Public Health Preparedness, St. Louis University School of Public Health, University of Kansas School of Medicine, KU Public Management Center,

Professional Associations, and Kansas Association of Local Health Departments (KALHD). Ongoing training activities include the Kansas Public Health Certificate Program, and the Kansas Public Health Leadership Institute.

Coordination with other Kansas MCHB Grants

KDHE staff are involved in numerous ways with grants that are awarded by MCHB to the State of Kansas. The BCYF is a partner agency in the on-going collaborative efforts between the Kansas Title V agency and the Kansas City Healthy Start (KCHS) and with the Healthy Start Initiative awarded to the Wichita-Sedgwick County Health Department. The Kansas University Affiliated Program at the University of Kansas Medical Center works closely with the CSHCN program staff and contract staff actually share office space with the program. BCYF staff currently serve on the advisory board for the Traumatic Brain Injury Implementation grant and have served in the past with the Healthy Child Care Kansas grant. Staff within the bureau directly administer community project funding for the Section 510 Abstinence Education Grant, Community Integrated Service Systems (CISS) -- State Early Childhood Comprehensive Systems planning and implementation grant, and the Universal Newborn Hearing Screening. MCH works with the Health Systems Development in Child Care, Emergency Medical Services for Children (EMSC) Partnership and Bioterrorism grants.

/2010/ MCH/CSHCN state staff report many significant collaborative activities during the past year. Collaboration with Heartland Genetics and Newborn Screening in Austin, Texas allows program staff to learn from the states within our region and enhances our program through networking and information sharing. Collaborative activities between newborn hearing screening (Sound Beginnings) and Part C of IDEA local agencies has decreased the loss to follow-up between diagnosis and early intervention. Collaboration with the KU Area Health Education Centers has facilitated ten regional trainings for over 150 nursing and laboratory staff who are involved in the collection of blood spot cards for newborn screening. Collaboration between SIDS Network of Kansas and Healthy Start Home Visitors has helped provide safe sleep environments for infants at risk of SIDS and other sleep related deaths. Safe 'Cribs for Kids' were distributed through this program. Collaboration with the data people in the state social service agency (SRS) has been very profitable and resulted in some program changes and explanation of the trends we see particularly for TANF. There has been ongoing sharing of research between SRS and KDHE and future meetings are planned with the possibility of MCH epidemiologists assisting with their data.

There has been strong collaboration among KDHE, KSDE, Kansas In-service Training System (KITS), local infant toddler networks and statewide school districts' Part B programs, to develop, implement, and provide user training for an outcomes web system that tracks a child's functional progress in three developmental outcomes. CSHCN and newborn screening have worked closely together during the expansion from four to 29 conditions. Information about new conditions has been shared to assure families receive diagnoses and treatments for their infants. Collaboration with the federal Healthy Start projects in Kansas City and Wichita has helped bring the state up to date about the value of Fetal-Infant Mortality Review. Collaboration with the Perinatal Association of Kansas during the past year has helped MCH. This is a multi-disciplinary group of professionals with expertise in providing perinatal care and education. Consultation is provided to the department to help improve state perinatal outcomes. An equally important collaborative activity is with the Kansas Chapter of the AAP. The state MCH/CSHCN agency and this group of child health professionals explore strategies to improve child and adolescent health outcomes. The newborn screening advisory council is a very strong group of specialty doctors, parents and staff that meet four times a year to make sure they are doing the right thing for babies of Kansas.

The Kansas Reconvene Team in which state health and education agencies obtained

training through the National Alliance of State and Territorial AIDS Directors, National Coalition of STD Directors, and others was instrumental in advancing a plan for building capacity in the areas of disparities and peer education. The fatherhood summit was a collaborative activity in which JJA, Catholic Social Services, KPIRC, and others developed a common goal, shared resources, provided educational events for families and providers to help people better care for their children.

A strong ongoing collaboration is between family planning and the breast cancer program, Early Detection Works. These two programs work together to help low-income women get follow-up care on their abnormal Pap smears. The child care health consultation training was an incredibly important collaboration among a variety of organizations/experts, Wichita State University, and KDHE. The project was a direct result of the collaboration between MCH and all the signators to the Kansas Early Childhood Comprehensive Systems State Plan. Another collaboration with the conveners of the SECCS Plan helped get training for MCH/CSHCN staff on Results-Based Accountability. A collaborative activity with K-State Research and Extension Department resulted in downsizing and redefining the activities of the Kansas Nutrition Network, the USDA State Nutrition Action Plan, and the annual MOU review and revision. The Kansas State Department of Education, Special Education Services has been a great partner during the last year. They have attended our meetings, have invited us to their annual Leadership Conference. We have at least monthly meetings that continue to build our partnership. Kansas business case for breastfeeding train the trainer grant has helped us build a coalition of partners committed to workplace reform and policies that better support families. The Medicaid/MCH Interagency Agreement defines collaborative activities between the two program as required by law. In 2009, an update to the document helped to strengthen our relationship. These are among the numerous collaborative activities and practices engaged in by the Kansas MCH/CSHCN. //2010//

F. Health Systems Capacity Indicators

Introduction

Kansas MCH monitors trends in Health Systems Capacity Indicators to determine what can be done from a policy or program perspective to maintain or improve the HSCIs. The MCH epidemiologists and the program staff confer to interpret the data. In partnership with other State Agencies, families and communities, the State MCH agency may develop new strategies for meeting the HSCIs.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	33.5	31.3	33.4	33.1	33.1
Numerator	632	588	649	649	649
Denominator	188782	187949	194100	196138	196138
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

The 2008 column is populated with 2007 data. 2008 data will be available Spring 2010.

Notes - 2007
Data Source: Kansas hospital discharge data, Kansas Hospital Association. Accessed through the Center for Health and Environmental Statistics, KDHE.

Data includes hospital discharges of Kansas residents from non-federal and non-state short-term (average length of stay less than 30 days) general and specialty hospitals whose facilities are open to the general public. Only discharges with asthma as a primary diagnosis were included.

Notes - 2006
Data Source: Kansas hospital discharge data, Kansas Hospital Association. Accessed through the Center for Health and Environmental Statistics, KDHE.

Data includes hospital discharges of Kansas residents from non-federal and non-state short-term (average length of stay less than 30 days) general and specialty hospitals whose facilities are open to the general public. Only discharges with asthma as a primary diagnosis were included.

Narrative:
/2009/ In Kansas, the rate of asthma hospitalizations has increased 6.9% from 31.3/10,000 in 2005 to 33.4/10,000 in 2006. For the years 2002-2006, asthma hospitalizations has fluctuated from a high of 35.3/10,000 in 2003 to a low of 31.3/10,000 in 2005.

The disparity between black non-Hispanic children, white non-Hispanic children, and Hispanic children is of continuing concern. The hospitalization rate for black non-Hispanic children is approximately two times that of white non-Hispanic or Hispanic children (all races), which may indicate poor access to medical homes, the need for better quality of care for children diagnosed with asthma, poverty and living conditions, or other factors.

The KDHE has initiated public health surveillance of this condition in children through the BRFSS and participation in the State Environmental Health Indicators Collaborative (SEHIC). The SEHIC developed standardized measures for adoption by States which Kansas has piloted with feedback to SEHIC. These indicators address: 1) chronic lower respiratory disease (CLRD) and asthma mortality; and, 2) asthma hospitalization. Also, there are developmental indicators exploring the use of emergency department (outpatient) visit data and medication dispensing as well as other measures of the burden of asthma. A workgroup has been convened to explore the development of a document that will reflect the burden of asthma in Kansas with the anticipated coordination of asthma surveillance in Kansas. //2009//

/2010/ In Kansas, the rate of asthma hospitalizations has slightly decreased 0.9% from 31.4/10,000 in 2006 to 33.1/10,000 in 2007. For the years 1998-2007, asthma hospitalization rate has no statistically significant increasing or decreasing trend.

The Office of Health Promotion, KDHE submitted a grant in April, 2009 to CDC. The Kansas Asthma Program (KAP) Work Plan is organized around six proposed goals for the 5-year project to be completed by August 31, 2014: 1) An operative statewide organization will define and guide Kansas asthma initiatives; 2) Regional and state level asthma data for Kansas will be collected, analyzed, and disseminated; 3) a comprehensive evaluation plan will be designed and implemented; 4) reduce disparities among populations disproportionately affected by asthma; 5) reduce state asthma hospitalization rate; and 6) increase the proportion of people with current asthma who report that they have received self-management education. More information can be found on the internet at http://www.kdheks.gov/bhp/download/Asthma_burden.pdf and http://www.kdheks.gov/bhp/download/Addressing_Asthma_in_Kansas.pdf //2010//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	88.4	87.6	88.7	89.4	89.4
Numerator	15765	16457	16834	17140	17295
Denominator	17841	18778	18968	19177	19351
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
DATA SOURCE: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2007-09/30/2008 (FFY 2008).

Numerator=Total eligibles receiving at least one initial or periodic screen.
Denominator=Total eligibles who should receive at least one initial or periodic screen.

Notes - 2007
Data Source: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2006-09/30/2007 (FFY 2007)

Numerator=Total eligibles receiving at least one initial or periodic screen.
Denominator=Total eligibles who should receive at least one initial or periodic screen.

Notes - 2006
Data Source: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2005-09/30/2006 (FFY 2006)

Numerator=Total eligibles receiving at least one initial or periodic screen.
Denominator=Total eligibles who should receive at least one initial or periodic screen.

Narrative:
/2009/ In FFY 2006, 88.7% of Medicaid-enrolled infants received at least one initial or periodic screen. This is a slight increase from the previous year (FFY 2005 - 87.6%). But overall, there has been much improvement in getting infants into care.

When evaluating the trend in the last 5 years (from 2002-2006), the increase in the percent of enrollees who received at least one initial or periodic screen is statistically significant. The percent of Medicaid-enrolled infants getting at least one screen increased 9.5%, from 81.0% in 2002 to 88.7% in 2006.

The number of enrolled infants (denominator) continues to increase each year, as does the number actually getting into services (numerator).

Families are linked with medical homes through local MCH agency services such as M&I and Healthy Start. MCH and CSHCN coordinate efforts with both public insurers (Medicaid,

HealthWave) and private insurers, and also with private providers (family practitioners, pediatricians). //2009//

/2010/ In FFY 2008 and 2009, 89.4% of Medicaid-enrolled infants received at least one initial or periodic screen. This is a slight increase from FFY 2006 (88.7%). Although the number of infants screened was up from last fiscal year (FY2008), the total number of Medicaid enrollees also increased and lead to same percentage as reported for last year--89.4%. Further support for leveling of the screen rate comes from the relatively consistent percentage of infants screened from 2004 and onwards--no net gains have been made since 2003. Overall, there has been much improvement in getting infants into care. For the years 2000-2008, there is a significantly increasing trend detected. //2010//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	80.1	70.3	67.4	38.3	66.0
Numerator	313	289	244	158	268
Denominator	391	411	362	412	406
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data Source: Kansas Medical Assistance Program reporting system, Well Child for HW21 report, report period: 10/1/2007-09/30/2008 (FFY 2008)

Numerator=Total eligibles receiving at least one initial or periodic screen.
Denominator=Total eligibles who should receive at least one initial or periodic screen.

Notes - 2007
Data Source: Kansas Medical Assistance Program reporting system, Well Child for HW21 report, report period: 10/1/2006-09/30/2007 (FFY 2007)

Numerator=Total eligibles receiving at least one initial or periodic screen.
Denominator=Total eligibles who should receive at least one initial or periodic screen.

SCHIP was temporarily impacted by the DRA citizenship documentation requirements during SFYs 06 and 07. It reduced the number of enrollees, delayed reauthorization of cases, and likely lowered the number of services provided.

Notes - 2006
Data Source: Kansas Medical Assistance Program reporting system, Well Child for HW21 report, report period: 10/1/2005-09/30/2006 (FFY 2006)

Numerator=Total eligibles receiving at least one initial or periodic screen.
Denominator=Total eligibles who should receive at least one initial or periodic screen.

Narrative:

/2009/ In FFY 2006, 67.4% of SCHIP-enrolled infants received at least one initial or periodic screen. This is a 4.1% decrease from the previous year (FFY 2005 - 70.3%). After reaching a high of 80% in 2004, there has been a steady decline in the percent of SCHIP infants receiving a screen.

SCHIP staff report that the highly irregular data is due to changes in their automation system, plus a change in SCHIP policy. The policy change removed the mandate that SCHIP infants be current on screens before any other medical services could be provided. Overall, over the past 7 years, it appears that the percent of infants with at least one initial or periodic screening may be just under 40%.

Also, comparing the Medicaid data to the SCHIP data, the SCHIP numbers and ratios are considerably lower. This is because SCHIP infants are only covered for/from their month of birth in the SCHIP program IF their mothers were enrolled in SCHIP and Kansas has very few teen mothers with incomes that would qualify them for SCHIP (only about 40 - 50 per year). Most of the infants in the program enter after the first few months of life, but before their first birthday. Generally speaking, most medical services and screenings for infants occur at or shortly after birth. So the screenings that would count for this indicator, usually occur prior to enrollment in SCHIP. //2009//

/2010/ SCHIP was temporarily impacted by the Deficit Reduction Act (DRA) citizenship documentation requirements during SFYs 06 and 07. It reduced the number of enrollees, delayed reauthorization of cases, and likely lowered the number of services provided. Therefore, the 2007 data is real.

In FFY 2008, 66.0% of SCHIP-enrolled infants received at least one initial or periodic screen. This is a 2.0% decrease from FFY 2006 (67.4%). After reaching a high of 80.1% in 2004, there has been a steady decline in the percent of SCHIP infants receiving a screen. //2010//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	81.4	79.2	78.5	77.4	77.4
Numerator	31854	28283	28831	30175	30175
Denominator	39150	35724	36734	38963	38963
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Fall 2009.

Notes - 2007
Data Source: Center for Health & Environmental Vital Statistics, KDHE

Numerator = Number of resident women (15-44) during the reporting calendar year whose

observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.
Denominator = All resident women (15-44) with a live birth during the reporting calendar year for which prenatal visits, date of first prenatal visit and date of last menses were reported on the birth certificate.

Data reliability is a concern for 2007 due to the high percent of missing data (date of first prenatal visit and date of last menses).

Notes - 2006
Data Source: Center for Health & Environmental Vital Statistics, Kansas Department of Health & Environment.

Numerator = Number of resident women (15-44) during the reporting calendar year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.
Denominator = All resident women (15-44) with a live birth during the reporting calendar year for which prenatal visits, date of first prenatal visit and date of last menses were reported on the birth certificate.

Data reliability is a concern for 2006 due to the high percent of missing data (date of first prenatal visit and date of last menses).

Narrative:
/2009/ The percent of Kansas women with a birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index (adequate and adequate plus prenatal care) was 78.5 percent in 2006. In the previous 5 years (2002-2006), this percent remained essentially the same in the years 2002 through 2004. When comparing 2005 and 2006 Kansas data, there was a slight decrease (0.9%).

According to the National Center for Health Statistics, prenatal care data based on the 2003 revised certificate (starting in 2005 for Kansas) presents a markedly less favorable picture of prenatal care utilization. This is true both in Kansas and nationally among states using the revised birth certificate. Since not all states have implemented the use of the new certificate format, Kansas data may not be comparable to that of other states. In previous years, the mother or prenatal care provider reported the month of pregnancy in which the mother began prenatal care and the number of prenatal care visits. As of 2005, this item was calculated with the exact dates of first and last prenatal visit and the last normal menses date.

In Kansas, the percent of women receiving adequate and adequate plus prenatal care in 2006 than in 2005 for all racial/ethnic groups except for the Asian non-Hispanic women. Analysis of adequate and adequate plus prenatal care separately shows that adequate PNC decreased for women of all races/ethnicities. This decrease was balanced in part by higher adequate plus prenatal care for all groups except black non-Hispanic and Hispanic women. This decrease in adequate and adequate plus prenatal care among different racial/ethnic groups may be partially explained by the Feb 8, 2006 Deficit Reduction Act which included new requirements for citizen documentation when renewing or applying for for Medicaid benefits.

For 2006, Hispanic (28.4%), Other non-Hispanic (23.8%) and Native American Non-Hispanic (23.7%) women were least likely to receive inadequate prenatal care. This data points to racial/ethnic disparities in access to prenatal care possibly due to legal status, cultural barriers, and/or other factors. //2009//

/2010/ The percent of Kansas women with a birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the

Kotelchuck Index (adequate and adequate plus prenatal care) was 77.4 percent in 2007, 1.4% decrease from the previous year (78.5%). Over the three year period (2005-2007), there was a decreasing trend detected, but no statistically significant. //2010//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	94.8	75.5	95.7	93.6	88.1
Numerator	254310	196212	220505	218191	220077
Denominator	268158	259866	230444	233207	249728
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
The numerator and denominator are entered in reverse. This causes the percentage to exceed 100%.

Data Source: Medicaid paid claims data file, Kansas Health Policy Authority (calendar year 2008).

Numerator = # of unduplicated consumers =249,728
Denominator = # of unduplicated Medicaid beneficiaries = 220,077

Percent = 113.5%

Consumer is any person with a paid service during a time period (including capitation payments for managed care plans which may not indicate actual utilization of services), and that Kansas has a 12-month timely filling requirement, so services performed in 2006 can be paid in 2007, and services in 2007 can be paid in 2008. Therefore, consumer counts are higher than beneficiary counts.

Notes - 2007
The numerator and denominator are entered in reverse. This causes the percentage to exceed 100%.

Data Source: Medicaid paid claims data file, Kansas Health Policy Authority (calendar year 2007).

Numerator = # of unduplicated consumers = 233,207
Denominator = # of unduplicated Medicaid beneficiaries = 218,191

Percent = 106.9%

Consumer is any person with a paid service during a time period (including capitation payments for managed care plans which may not indicate actual utilization of services), and that Kansas has a 12-month timely filling requirement, so services performed in 2006 can be paid in 2007, and

services in 2007 can be paid in 2008. Therefore, consumer counts are higher than beneficiary counts.

Notes - 2006
Data Source: Medicaid paid claims data file, Kansas Health Policy Authority (calendar year 2006).

Numerator = # Medicaid enrollees (age1-21) who received a service during the reporting year.
Denominator = # Medicaid enrollees (age1-21) during the reporting year.

Narrative:
/2009/ For CY 2006, 220,505 Kansas children and young adults ages 1-21 received at least one service resulting in a Medicaid claim.

The number of Medicaid-enrolled children receiving at least one service increased from 170,513 (94.2%) in 2002 to 220,505 (95.7%) in 2006, a statistically significant increase. The percent receiving at least one service has fluctuated probably due to Medicaid database problems with a low in 2005 of 75.5%.

Even though the percent receiving at least one service shows an increasing trend over the last 5 years, the numbers of participants (denominator) and the numbers age 6-9 receiving dental services (numerator) were lower in 2006 compared to 2004. This is probably due to imposition of checks for residency status in 2006.

The local MCH agencies and school nurses continue to promote a medical home for every child and regular preventive checkups. //2009//

For CY 2007, 218,191 (93.6%) Kansas children and young adults ages 1-21 received at least one service resulting in a Medicaid claim. This is a 2.2% decrease from CY 2006.

/2010/ Please note that for 2007 and 2008, the numerator and denominator are entered in reverse (because the percentage cannot 100%). The number of Medicaid-enrolled children receiving at least one service increased from 233,207 (106.9%) in 2007 to 249,728 (113.5%) in 2007.

Numerator: # of unduplicated consumers
Denominator: # of unduplicated Medicaid beneficiaries

Consumer is any person with a paid service during a time period (including capitation payments for managed care plans which may not indicate actual utilization of services), and that Kansas has a 12-month timely filling requirement, so services performed in 2006 can be paid in 2007, and services in 2007 can be paid in 2008.

Beginning with SFY 2007, Kansas Department of Social and Rehabilitation Services (SRS) implemented a PIHP (Prepaid Inpatient Health Plan) and PAHP (Prepaid Ambulatory Health Plan) waiver for substance abuse treatment and mental health services. With those waivers, all Medicaid persons not in a nursing home or incarcerated are now enrolled in a managed care organization for these services and a capitation payment is made for each person, each month. The timely filling requirements and the newer waiver payments may help explain why consumer counts are higher than beneficiary counts. //2010//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	47.2	50.5	53.0	53.8	56.3
Numerator	18650	20835	22649	22791	24094
Denominator	39480	41252	42710	42376	42826
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
DATA SOURCE: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2007-09/30/2008 (FFY 2008)

Numerator=Number of eligible receiving any dental services.
Denominator=Number of individuals eligible for Kan Be Healthy.

Notes - 2007
Data Source: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2006-09/30/2007 (FFY 2007)

Numerator=Number of eligible receiving any dental services.
Denominator=Number of individuals eligible for Kan Be Healthy.

Notes - 2006
Data Source: Kansas medical assistance program reporting system, KAN Be Healthy annual participation report, report period: 10/1/2005-09/30/2006 (FFY 2006)

Numerator=Number of eligible receiving any dental services.
Denominator=Number of individuals eligible for Kan Be Healthy.

Narrative:
/2009/ The number of children ages 6-9 who are enrolled in Medicaid (eligible for EPSDT services) has increased steadily over the last five years. The percentage of children who access dental services also continues to rise. Whereas only 37.5% received a dental service in 2002, 53% were receiving services in 2006. When evaluating the trend in the last 5 years (from 2002-2006), the increase in the percent of children enrolled who have received any dental services is statistically significant (p-value <.0000).

The MCH program continues to play a key role in establishment of partnerships within and outside the Agency to improve access to dental services for both mothers and children. //2009//

/2010/ There has been a statistically significant increase in eligible children receiving dental services over the last five years. This year alone there was a 4.6% increase. This is a net increase of 1,061 screens over last year. //2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	42.5	36.2	100.0	100.0	100.0
Numerator	2499	2196	6790	6335	6822
Denominator	5875	6072	6790	6335	6822
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

DATA SOURCE: Healthy and Ready to Work National Resource Center. Table—Number and percentage distribution of children in Kansas receiving federally administered SSI payments, by selected characteristics, December 2008. Further information can be found at http://www.hrtw.org/youth/data.html#ssi

Title V no longer has access to SSA Data. Starting FY2006, a proxy measure is used. All children 16 years or less who are SSI recipients are required to enroll in Medicaid. It assumed that enrollees receive rehabilitative services.

Notes - 2007

Title V no longer has access to SSA Data. Starting FY2006, a program measure is used. All children 16 years or less who are SSI recipients are required to enroll in Medicaid. It assumed that enrollees receive rehabilitative services.

Notes - 2006

Data Source: Numerator=Social Security Administration, December 2006.
Denominator=Social Security Administration, December 2006.

Reporting mechanism has changed due to the fact that SSA no longer allows monthly printouts and disability determinations be sent to the CSHCN program. All clients receiving SSI are eligible for Medicaid in Kansas and therefore have access to needed rehabilitation services through Medicaid coverage.

Narrative:

/2009/ The CSHCN program has a good working relationship with the Kansas Department of Social and Rehabilitative Services where the Kansas Disability Determination agency is housed. During the last year due to SSA requirements the CSHCN no longer receives monthly printouts or Disability Determination forms for those clients in Kansas receiving SSI benefits. CSHCN continues to have access to SSA data screens that allow staff to verify current eligibility. The CSHCN program has worked with the Regional SSA office to continue the data screens with modification of data sharing agreements on an annual basis.

The CSHCN program sends application forms to families of children who receive SSI and are not medically eligible for the CSHCN program. No new referrals are formally sent to CSHCN, but negotiations are underway to obtain referrals from the Kansas Disabilty Determination unit as appropriate.

This year, 100% of State SSI beneficiaries less than 16 years old received rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program. This is because all children eligible for SSI are eligible for Medicaid in Kansas and Medicaid provides full coverage of services. //2009//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2007	payment source from birth certificate	8.6	6.5	7.1

Notes - 2010
Data source: Birth certificate (resident) data, 2007. Center for Health and Environmental Statistics, KDHE. Live births are excluded when the prenatal care start dates and/or payor source are unknown or missing.

Narrative:
/2009/ According to 2006 birth certificate data, Medicaid paid for the delivery of 10,824 (28.0%) Kansas live births. There is some concern that this number/percent may be too low. The payor may be classified as self pay at the time the birth certificate data is collected and later designated Medicaid (SOBRA). The payor was known in 95% of live births.

Birth certificate data (2006) indicates 7.0% of Kansas births were low birthweight. For Medicaid births, 8.7% were low birth weight compared to 6.3% for non-Medicaid births.

Studies show that income status impacts both health status and access to care. Medicaid data for Kansas support this. Medicaid enrolled women are least likely to have positive birth outcomes possibly due to greater likelihood of poor preconception health, preconception and prenatal risk behaviors, limited access to early prenatal care and social supports, as well as possible greater exposure to prenatal stress.

MCH provides medical prenatal care and prenatal care coordination services to low-income and high risk women. Healthy Start home visitors link women and their families with community services and supports. //2009//

/2010/ According to 2007 birth certificate data, Medicaid paid for the delivery of 9,954 (24.9%) Kansas live births, a 11.1% decrease from 2006 (28.0%). There is some concern that this number/percent may be too low. The payor may be classified as self pay at the time the birth certificate data is collected and later designated Medicaid (SOBRA). The payor was known in 95.5% of live births.

Birth certificate data (2007) indicates 7.1% of Kansas births were low birthweight. For Medicaid births, 8.6% were low birth weight compared to 6.5% for non-Medicaid births (where delivery payor is known). //2010//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 *Comparison of health*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-	ALL

system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State				**MEDICAID**	
Infant deaths per 1,000 live births	2007	matching data files	9.2	7	7.5

Notes - 2010
Data source: Linked death and birth file, 2007 death cohort. Center for Health and Environmental Statistics, KDHE.

Narrative:
/2009/ For the time period represented by this data, the infant mortality rate was highest for the Medicaid service population (9.1%) and lowest for the non-Medicaid population (5.8%). The overall infant mortality rate for Kansas was 7.0% where the delivery payor was known.

The MCH program has collaborated with the Kansas City federal Healthy Start Program to conduct Fetal-Infant Mortality Review (FIMR) recommended by the ACOG and the AAP as a best practice strategy in helping communities identify the systems issues that need to be addressed to prevent infant deaths. Also, the Kansas Center for Health and Environmental Statistics and the federal Healthy Start program in Wichita will pilot a Fetal-Infant Mortality Program in the Wichita area to assist the community in addressing this public health concern. //2009//

/2010/ In 2007, the infant mortality rate was highest for the Medicaid service population (9.2%) and lowest for the non-Medicaid population, where delivery payor is known (7.0%). The overall infant mortality rate for Kansas was 7.5%. //2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	payment source from birth certificate	56.8	75.7	68.4

Notes - 2010
Data source: Birth certificate (resident) data, 2007. Center for Health and Environmental Statistics, KDHE. Live births are excluded when the prenatal care start dates and/or payor source are unknown or missing.

Narrative:
/2009/ In 2006, 72.5% of Kansas infants were born to women receiving prenatal care (PNC) beginning in the first trimester of pregnancy. Only about 60% of Kansas Medicaid infants were born to women receiving PNC in the 1st trimester of pregnancy. Those not participating in

Medicaid had the best access to early prenatal care at 77.7%.

The eligibility level for pregnant women for Medicaid coverage in Kansas is 150% federal poverty level (FPL). Low-income undocumented women can qualify for Medicaid coverage under the Sixth Omnibus Budget Reduction Act (SOBRA). Both poverty status and undocumented status have been associated with delayed prenatal care.

The 2005 MCH Needs Assessment established access to health care for all women of reproductive age as a priority need for Kansas. This priority includes both access to preconception care and access to prenatal care. See State Performance Measure #1 for Kansas public health initiatives to address this concern. //2009//

/2010/ In 2007, 68.4% of Kansas infants were born to women receiving prenatal care (PNC) beginning in the first trimester of pregnancy. Only 56.8% of Kansas Medicaid infants were born to women receiving PNC in the 1st trimester of pregnancy. Those not participating in Medicaid (where delivery payor is known) had the best access to early prenatal care at 75.7%. //2010//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	payment source from birth certificate	63.4	78.7	72

Notes - 2010
Data source: Birth certificate (resident) data, 2007. Center for Health and Environmental Statistics, KDHE. Live births are excluded when the prenatal care start dates and/or payor source are unknown or missing.

Narrative:
/2009/ Kansas' performance on this indicator has declined since the implementation in 2005 of the 2003 revision of the U.S. standard certificates and reports by Kansas Vital Statistics. Regardless of this change, the data continue to show that adequacy of prenatal care is better for non-Medicaid than for Medicaid-enrolled women. In 2006, 74.1% of all livebirths were to women with adequate or adequate plus prenatal care. For Medicaid-enrolled women, 62.4 percent had adequate or adequate plus prenatal care, compared to 78.6% for non-Medicaid livebirths (where delivery payer is known).

Medicaid status is an indicator of poverty. Medicaid births include those covered by Sixth Omnibus Budget Reduction Act (SOBRA) for labor and delivery of undocumented women who meet the income eligibility requirements. Both poverty status and undocumented status have been shown to be associated with delayed prenatal care.

The 2005 MCH Needs Assessment established access to health care for women of reproductive age as a priority need for Kansas. This priority includes access to prenatal care. See State Performance Measure #1 for Kansas public health initiatives to address this need. //2009//

/2010/ In 2007, 72.0% of all livebirths were to women with adequate or adequate plus prenatal care. For Medicaid-enrolled women, 63.4 percent had adequate or adequate plus prenatal care, compared to 78.7% for non-Medicaid livebirths (where delivery payor is known). //2010//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	200

Notes - 2010
DATA SOURCE:
Kansas Health Policy Authority. Medicaid program eligibility requirements.

Notes - 2010
DATA SOURCE:
Kansas Health Policy Authority. Healthwave program eligibility requirements.

Narrative:
/2009/ Kansas uses the federal minimum eligibility requirements for both Medicaid and SHCIP. Infants are eligible for Medicaid at 150% of the federal poverty level (FPL). Infants are eligible for SCHIP at 200% FPL.

Given the economic downturn for the State, there is declining interest among the legislators in expansion of these programs. This is the case despite health care reform plans and public pressure. Instead, Kansas legislators have supported expansion of charitable and primary care clinics as providers of care to low-income individuals. //2009//

/2010/ Effective January 1, 2010, an estimated 8,000 more uninsured Kansas children will be eligible for health coverage that allows them to get preventive care and to see a doctor when they get sick. The 2009 Legislature approved funding (HB 2354) that will extend eligibility for HealthWave, the state childen's health insurance program (SCHIP) in Kansas, to 250% of poverty. More kids will be able to get the health care they need at a price their parents can afford. //2010//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**

pregnant women.		
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2008	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2008	 200 200

Notes - 2010
DATA SOURCE:
Kansas Health Policy Authority. Medicaid program eligibility requirements.

Notes - 2010
DATA SOURCE:
Kansas Health Policy Authority. Healthwave program eligibility requirements.

Narrative:
/2009/ Kansas follows the federal minimum eligibility requirements. Children ages 1 though 5 are eligible for Medicaid at 133% FPL and children ages 6 through 18 are eligible at 100% FPL. Children in both age groups are eligible for SCHIP at 200% FPL. //2009//

/2010/ Effective January 1, 2010, an estimated 8,000 more uninsured Kansas children will be eligible for health coverage that allows them to get preventive care and to see a doctor when they get sick. The 2009 Legislature approved funding (HB 2354) that will extend eligibility for HealthWave, the state childen's health insurance program (SCHIP) in Kansas, to 250% of poverty. More kids will be able to get the health care they need at a price their parents can afford. //2010//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	200

Notes - 2010
DATA SOURCE:
Kansas Health Policy Authority. Medicaid program eligibility requirements.

Notes - 2010
DATA SOURCE:
Kansas Health Policy Authority. Healthwave program eligibility requirements.

Narrative:
/2009/ Kansas follows the federal minimum eligibility requirements for both Medicaid and SCHIP. Pregnant women are eligible for Medicaid whose incomes are at or below 150% FPL. At 60 days postpartum eligibility for women drops to less than 35% FPL. Pregnant women are eligible for SCHIP who meet both the age and income eligibility requirements (incomes below 200% FPL). //2009//

/2010/ The 2009 Legislature approved funding (HB 2354) that will extend eligibility for HealthWave, the state children's health insurance program (SCHIP) in Kansas, to 250% of poverty. This expansion of eligibility is effective January 1, 2010. Pregnancies are covered under this program if within the age guidelines for the program. //2010//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	2	Yes
Survey of recent mothers at least every two years (like PRAMS)	1	No

Notes - 2010

Narrative:
/2010/ The MCH program has access to database linkages, registries and surveys as above except for the following: annual linkage of birth certificates and WIC, and survey of recent

mothers at leastt every two years (Prenatal Risk Assessment Monitoring System - PRAMS). A birth defects surveillance (BDSS) module is in near completion that interfaces with the CYSHCN web-based system. This will improve our standing with respect to the CDC standards for birth defects surveillance systems. Hospital discharge survey data are available for at least 90% of in-State discharges.

The MCH program has direct access to data files for: infant birth certificates, infant death certificates, birth defects, hospital discharge data, WIC, and newborn screening files. MCH has indirect access to data files for Medicaid Eligibility and Paid Claims files.

Linked infant birth and death certificates files: The linkage between birth records and infant death certificates is maintained. BPHI links all deaths to Kansas residents, including infants, to the Kansas live birth certificate. As needed, BPHI provides a linked birth-death cohort file for special analyses by the SSDI coordinator and MCH epidemiologist. Based on anecdotal reports of the limited utility of the annual Perinatal Casualty Reports, BPHI will consider redesigning the reports in order to better meet the QA/QI needs of the hospitals that express a desire to receive the reports. The Kansas Perinatal Council (KCP) reviews the data as well. BPHI continues to pursue opportunities for producing special analyses of the data.

Birth certificates and Medicaid Eligibility or Paid Claims Files and WIC eligibility files: Capacity exists but no new work has been done this area. BPHI completed the project matching birth records with both the mother's and the child's Medicaid eligibility files, as well as with the Medicaid paid claims files. The final report, "WIC-Medicaid-Vital Statistics Birth Records Matching" was completed in November 2003. In 2006, administration of the State's Medicaid program was transferred from Kansas Department of Social and Rehabilitation Services (SRS) to the Kansas Health Policy Authority (KHPA) and BPHI began negotiating with KHPA for Medicaid data. BPHI has begun receiving Medicaid claims data. BPHI, MCH, and WIC continues to seek out funding opportunities to support program activities to link birth, Medicaid and WIC data as well as to perform special analyses of the linked data.

Birth certificates and WIC eligibility files and Immunization registry: The linkage between birth records, immunization data, and WIC eligibility files is effective on June 15, 2009. The data will be available on a regular basis for analysis. WIC will coordinate to build a report on WebIZ (Immunization registry) to produce timely estimates of vaccination coverage rates of children participating in WIC for all childhood vaccinations recommended by the Advisory Committee on Immunization Practices.

Birth certificates and newborn metabolic screening files: The linkage between birth records and newborn metabolic screening files exists, but data quality is questionable. KDHE's Information Technology (IT) staff maintains an application to link the Kansas Health and Environmental Laboratories (KHEL) newborn screening files to selected BPHI birth record fields. Due to lack of funding and personnel changes, KHEL has not been able to continue conducting data quality reviews especially since matching the files is a manual process for the laboratory. MCH is working with IT, BPHI and KHEL to identify ways to continue this process and improve quality. Therefore, currently MCH cannot access these files. This linkage is being reevaluated with expansion of the Newborn Screening program.

Hospital discharge data: Hospital discharge data is maintained by BPHI. BPHI acquires the hospital discharge data gathered by Kansas Hospital Association (KHA) through the Kansas Health Policy Authority (KHPA). All Kansas community hospitals submit data to KHA. SSDI coordinator used the hospital discharge data to respond to a concern about the increased incidence of cystic hygroma (a cluster investigation) referred to the Maternal Fetal Medicine over the 4-5 months time. In Kansas, birth defects are reportable and

collected through two data sources: birth certificates and the birth defects prevention program reporting form. Since there is no way to extract the data on a specific condition such as cystic hygroma in either of those systems to determine if numbers reported are in excess of what we might expect, the hospital discharge data were utilized. This data also contains discharge data on Kansas residents who were treated at hospitals in adjacent states to give more complete information.

BDSS: A birth defects surveillance module is near completion that interfaces with the CYSHCN web-based system. SSDI and MCH funds support this process. MCH plans to use the data from the enhanced system to improve access. Families are notified of the availability of services and supports through CYCHSN, early intervention, and other programs.

PRAMS: Kansas submitted an application in response to the CDC request for proposal (RFP) for PRAMS 2006 Cooperative Agreements. The Kansas application received a priority score, but unfortunately, it was not recommended for funding at this time. //2010//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
Kansas Youth Tobacco Survey	3	Yes

Notes - 2010

Narrative:

/2010/ Youth Risk Behavior Survey (YRBS):

The YRBS is part of a biennial national effort led by CDC and is conducted by the Kansas State Department of Education (KSDE) and KDHE in partnership with local school districts. The YRBS monitors health risks and behaviors in six categories, which are related to the leading causes of mortality and morbidity among both youth and adults. Data is collected on behaviors that contribute to physical activity, nutrition, tobacco use, alcohol and other drug use, violence and injuries, and sexual behaviors. During the spring of 2005, KSDE and KDHE conducted the YRBS in 41 Kansas high schools. For the first time in Kansas YRBS history, weighted data was obtained. The surveys were completed by 1,652 students in grades 9 through 12. In 2007, Kansas again achieved weighted data for the YRBS. In that school year, YRBS was completed by 1,733 students in 49 public schools. The sample population was 48.5% female and 51.5% male. The survey results provide useful information that can be used to make important inferences about 9th through 12th grade students statewide due to the research based method of random selection used to gather the data (e.g., state performance measure 4 - children and adolescents behavioral/mental health). Compiled results from the 2005 and 2007 Kansas YRBS can be found on the Kansas Coordinated School Health Program website at www.kshealthykids.org. Data collection for 2009 Kansas YRBS is nearly complete and, when available, results will be released to statewide partners for the development of programs to address identified needs.

Kansas Coordinated School Health (KCSH), which is a section of the Office of Health Promotion (OHP) at KDHE and is a shared program with KSDE, is currently conducting the YRBS in Kansas high schools for the 2008-2009 school year. KCSH will continue to share the data received with partners across the state. There are discussions about

administering the YRBS at the middle school level, but Kansas would like to obtain trend data at the high school level before adding the middle school survey. Steps are being taken to increase collaboration with other agencies that administer school surveys and to develop partnerships at the state level to reduce survey burdens on schools, while maintaining the integrity of the data.

Previously, the data was not considered representative of the youth population due to non-participation of some school districts. For the last three survey sessions, through joint work by KCSH, KSDE and KDHE, Kansas has been able to collect quality, weighted data that is representative of the health behaviors of all students in the state. The data is also useful to the Title V program in tracking youth health behaviors. The OHP will continue to work through Kansas Coordinated School Health in partnership with local school districts to maintain this level of participation.

Kansas Youth Tobacco Survey:
The purpose of the Kansas Youth Tobacco Survey (YTS) is to monitor the prevalence, attitudes and knowledge, and other aspects of tobacco use, physical activity, and nutrition among adolescents in grades 6 to 12. Survey methodology includes a stratified two-stage cluster sampling design with first stage of random selection of schools in Kansas containing grades 6 to 12 and then second stage of random selection of classes within each school. For statewide weighted estimates, approximately 4,000 students in grades 6 to 12 are surveyed.

These data are important for determining burden of tobacco use, related social factors, perception about tobacco use and initiation susceptibility among youth. Data are also used to determine tobacco control programming and evaluation of program components for their effectiveness in Kansas. The YTS also provide data for nutrition and physical activity components of Health Promotion in Kansas.

The YTS is conducted every two school years. The YTS was conducted in 2000, 2002, 2006 and 2007. Community specific YTS were conducted in 9 communities in 2000, in 7 communities in 2002, in 4 communities in 2004, and in 17 communities in 2006/2007. The surveys have been analyzed, and the associated reports and fact sheets are released. The survey will be conducted again in 2009. //2010//

IV. Priorities, Performance and Program Activities

A. Background and Overview

/2009/ In Kansas, high standards of accountability apply to all maternal and child programs. This is due to scarcity of resources at the federal, state and local levels and through other funding sources such as foundations. Legislators and others require regular reports on best practices, performance and outcomes. Increasingly data is linked to funding decisions, mostly to achieve efficiencies but also to improve outcomes for certain target populations. The State budget including the BFH budget is based on performance and outcome measures linked to the spending plan. The Legislature requires strict accountability through annual reports and special reviews. An example of a special review is the Legislative Post Audit study on KDHE programs that address low birthweight. Other funding sources such as the Children's Cabinet which provides oversight of Tobacco Settlement funds requires each recipient of funds to provide an annual program evaluation summary including performance and outcome data.

Since 1999 BFH has included performance plans and performance information in its federal MCH budget submission. BFH submits annual reports to Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB) on the actual performance achieved compared to that proposed in the performance plan. This Section of the Kansas MCH Services Block Grant Application describes how the State-Local partnership will implement the federally-required performance reporting requirements.

The MCH Block Grant Performance Measurement System is an approach utilized by Kansas that begins with the state/local needs assessment and identification of priorities. It culminates in improved outcomes for the maternal and child population. After Kansas establishes its priority needs for the five-year statewide needs assessment, programs are developed based on best practices, assigned resources, and implemented to specifically address these priorities. Specific program activities are described and categorized by the four service levels found in the MCH Pyramid: direct health care services, enabling services, population-based activities, and infrastructure-building activities. Since there is flexibility available to Kansas in implementing programs to address priority needs, the program activities or the role that MCH plays in the implementation of each performance measure may be different from that of other states. Kansas tracks its individual progress on up to ten unique State performance measures and Kansas tracks its progress on all national performance measures and compares its performance with the performance of other states using the Maternal and Child Health Bureau's Title V Information System.

Accountability in BFH programs is determined in three ways: (1) by measuring the progress towards successful achievement of each individual performance measure; (2) by budgeting and expending dollars in each of the four recognized MCH services: direct health care, enabling services, population-based activities, and infrastructure-building activities; and (3) by having a positive impact on the outcome measures.

While improvement in outcome measures is the long-term goal, more immediate success may be realized by positive impact on the performance measures which are shorter term, intermediate, and precursors for the outcome measures. This is particularly important since there may be other significant factors outside BFH control affecting the outcomes. //2009//

B. State Priorities

/2009/ The Kansas comprehensive needs assessment, MCH 2010, was completed in 2005. In all, nine priority needs were identified, three for each population group served by the MCH Services Block Grant. This narrative will describe each priority need, Kansas capacity and resources to address each need, and relation of each to the national and state performance

measures.

PREGNANT WOMEN AND INFANTS

1. Increase early and comprehensive health care before, during and after pregnancy.

This priority need was selected based on state and regional Perinatal Periods of Risk (PPOR) analysis. As a tool to identify excess mortality and to suggest reasons for excess mortality, PPOR was used to suggest which community interventions were most likely to result in improved health outcomes. Kansas data pointed to a need to target the area of Maternal Health/Prematurity and corresponding preconception health, health behaviors, and perinatal care. MCH directs resources to address this need at both the state level, and at the community level through grants to local agencies. In addition, through partnerships with stakeholders such as private physicians, March of Dimes, Medicaid, other federal programs, MCH guides policy decision-making and coordinates efforts.

NPMs 8, 15, 1, 18 and NOMs 1, 2, and 3 relate to this priority need.

2. Reduce premature births and low birthweight.

This priority need was selected based on data showing slight increases for Kansas (see HSA #01A) and the U.S. and data-driven research which points to effective public health interventions. Kansas has the capacity to address this priority through prenatal smoking cessation, improved nutritional status, and community-based prenatal case management and care coordination for low-income and high risk women.

NPMs 8, 15, 18 and SPMs 1 and 2 and NOMs 1-3 relate to this priority.

3. Increase breastfeeding.

The positive benefits of breastfeeding both for the mother and infant are provided in the discussions for NPM 11 and SPM 3. Kansas capacity to address this priority is significant due to partnerships forged across programs including WIC and women's health, due to the low cost of interventions and high yield in health benefits, and finally, due to a change in public attitudes and policy supporting breastfeeding mothers in the community and in the workplace. Kansas has devoted resources to peer education, health promotion and health education efforts, plus public information and education to address this priority.

NPM 11 and SPM 3 are the same. Kansas considered revising its priority after the new NPM 11 was released but chose not to do so out of respect for stakeholder input in the 5-year MCH State Needs Assessment process. If anything, the selection of breastfeeding duration as a priority at both the national and state levels validates our process and lends added weight to the priority.

CHILDREN AND ADOLESCENTS

4. Improve behavioral/mental health.

This priority was held over from the last five year needs assessment due to concern that more needs to be done in this area and more can be accomplished through prevention, early identification and intervention in the public health arena. Kansas' capacity is mostly in the areas of early identification and intervention through screening and referrals to treatment. Health promotion and public education to address high risk behaviors of youth are needed as well as family supports in the community.

NPMs 8, 16, and SPOM 6 relate to this priority.

5. Reduce overweight.

This priority need was selected based on Kansas WIC data showing an increasing trend even among very young Kansans and the strong association between overweight and health status. Most other efforts in Kansas focus on the needs of school-age and adult nutrition and physical activity. The Kansas priority was selected prior to the release of the national priority but it different in one respect, the selection of performance measure. The State performance measure tracks progress in reducing overweight young children (body mass index at or above 95th percentile) whereas the national performance measure is broader and tracks progress in reducing overweight and at risk overweight among children (body mass index at or above 85th percentile). The priority is significant enough that it is useful to track both measures and also to retain the priority as a state priority selected by stakeholders. Kansas capacity to address overweight is enhanced through MCH grants to local communities, school nurses, and also the Governor's Healthy Kansas Initiative. This latter initiative is a replication of the Healthy Arkansas initiative and focuses on lifestyle changes and state/community policy through health education, health promotion, and publications. The effort involves both public and private sectors including the business community and such activities as nutrition education for youth and parents, school health policy, healthy eating options in restaurants, walking trails, and so forth. The Kansas SPM on breastfeeding relates to this objective.

NPM 14 and SPM 5 are related to each other. NPM 11 and SPM 3 relate to this priority.

6. Reduce injuries and deaths.

Nationally and in Kansas, unintentional injury is the leading cause of death for children and adolescents. Kansas is consistently higher than the U.S. in some significant areas (see HIS #3A-3C and #4A-4C). Kansas capacity to address this issue is strengthened through partnerships with the Injury Prevention Program in the Office of Health Promotion, through the statewide SAFE Kids Coalition, and through local MCH agencies and education agencies. The Injury Prevention Program, in particular, utilizes the local school nurse network and the local MCH agency network to address injuries due high risk behaviors of youth, fire/burn injuries (home visitor smoke detector distribution), accidental poisonings (MCH distribution of Poison Control hotline number to parents), and motor vehicle crashes (safety seat installation and checks).

NPM 10, 16, and NOMs 1, 4, and 6 relate to this priority need.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

7. Increase care within a medical home.

This state performance measure holds for all children but in particular for CSHCN. Kansas capacity in this area is expanding to include development of data collection (new application form and survey systems), tracking systems (new CSHCN data system linked to Immunization Registry), parent/provider education about the medical home concept and practice, and linkages to other programs (Newborn Hearing Screening Learning Collaborative).

NPM 3 relates to this Kansas priority although NPM3 is broader and encompasses two concepts: family partnering in decision-making and care within a medical home. Kansas is developing interventions to address both and is developing capacity to track progress.

8. Improve transitional service systems for CSHCN.

Kansas capacity in this area has improved considerably with the realignment of staff duties to include a focus on transitional systems. This has resulted in new and enhanced partnerships with

organizations in the disability community and a refocusing of state efforts on the needs of youth with special health care needs (YSHCN) as they transition to adult medical care.

NPMs 2-6 relate to this state priority.

9. Decrease financial impact of CSHCN on families.

Kansas capacity in this area is enhanced through close working relationships with public programs (such as WIC and Farmworker Health) and public insurance (Medicaid and SCHIP). Direct financing of services through CSHCN dollars has become more restrictive due to dwindling state and federal dollars and rising costs. Hospitals, labs and private providers continue to work with CSHCN despite reductions in amount of coverage available. Private insurance coverage may only partially offset financial burden to the family or not at all. Rising numbers of uninsured and underinsured add to the ongoing challenge for the program. CSHCN continues to engage in policy decisions to ration limited dollars.

NPMs 2-6 relate to this State of Kansas priority. //2009//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	25	52	50	40	40
Denominator	25	52	50	40	40
Data Source					Kansas Newborn Screening data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
DATA SOURCE:

Data for 2008 is not available at the time of this application. 2007 data was used to pre-populate this peformance measure.

Notes - 2007
DATA SOURCE: KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2007 .

Notes - 2006
Data Source: Kansas Newborn Screening program, 2006.

a. Last Year's Accomplishments
Direct Services:

Medical consultation for children with genetic/metabolic conditions was available statewide through the CSHCN contractual process. CSHCN purchased metabolic formula and food products for individuals with phenylketonuria (PKU) and Maple Syrup Urine Disease (MSUD) along with treatment products for Sickle Cell Disease and Congenital Hypothyroidism. July of 2008, with the expansion of newborn screening (NBS), CSHCN implemented a sliding fee scale for use with all families with children identified through the NBS process including those infants with cystic fibrosis.

Enabling Services:

Kansas hospital personnel collected blood spot specimens from day old infants. Specimens were sent by hospital staff to the State public health laboratory for processing. Lab staff notified the NBS follow-up program of abnormal screening results. The NBS program notified the primary care physician (PCP) of the screening test results. Also, the PCP was informed of consultation and referrals available through the CSHCN program. Parents were notified of the need for follow up with the PCP regarding abnormal screening results. If the PCP that is listed on the blood spot card is not their PCP, we ask the family to notify the follow-up program. The NBS follow-up program provided case management services to assure that all infants had appropriate testing, diagnosis, referral and treatment services.

KDHE began sending postcards to parents of infants with congenital anomalies, low Apgar scores and low birth weights informing them about services available through KDHE programs including: CSHCN, Part C, Oral Health, WIC and immunizations.

Infrastructure Building Services:

During 2008 KDHE implemented expansion of the NBS testing to include the core panel of 29 conditions recommended by the American College of Medical Genetics (ACMG). An Advisory Council was convened to guide the implementation and evaluation process and has met on a quarterly basis.

Staff from the NBS follow-up program met approximately 2 times per month with laboratory staff in order to coordinate expansion activities and troubleshoot issues. Staff from the State public health laboratory has participated in tandem mass spectrometry (MS/MS) training and one member of the follow-up team participated in tandem mass spectrometry (MS/MS) training at Duke University during 2008.

The NBS webpage on the KDHE website has expanded during 2008 to include information for both parents and physicians related to the 29 conditions.

NBS follow-up staff worked with laboratory, vital statistics and information systems staff within KDHE to enhance our data linkages.

NBS staff revised the Newborn Screening Practitioner's Manual and have posted the Manual on the KDHE website. Staff worked with physicians, parents, genetic counselors and others to revise the ACT and FACT sheets to coincide with Kansas screening and referral guidelines. We also revised and developed Public Relation and informational materials.

Staff initiated a comprehensive strategy for reducing the numbers/rates of unsatisfactory specimens received from hospitals. Training was initiated with targeted hospitals that had a high rate of births and unsatisfactory samples.

NBS follow-up staff follow up with physicians and parents of infants with unsatisfactory newborn screening specimens assuring that babies return for needed repeat specimens as soon as possible.

KDHE Contracted with DNAXPRT, Inc. to obtain the services of two certified genetics counselors (2 of 4 in the State) to assist with development of provider and patient materials, plus direct patient counseling as necessary.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide nursing case management to families that have infants with abnormal newborn screens.		X		
2. Assure that contracts provide statewide coverage for consultations on NBS conditions.				X
3. Purchase and distribute treatment products to eligible individuals.	X			
4. Arrange transportation, as needed, for follow-up services.		X		
5. Manage data collection and reporting systems for NBS follow-up and birth defects information.				X
6. Provide information to policy makers on MS/MS laboratory and follow-up procedures.				X
7. Notify parents and medical providers about abnormal lab results and follow-up recommendations.		X	X	
8. Provide educations materials such as pamphlets, handouts, DVD and website address to parents and medical providers.		X		
9. Participate in the newborn screening advisory committee to include QA activities.				X
10.				

b. Current Activities

Direct Services:

Continue last year's services.

NBS follow-up staff works closely with CSHCN staff to assure diagnostic testing is available for patients identified by the NBS program.

Enabling Services:

Continue last year's services.

Infrastructure Building Services:

Continue to contract with certified genetic counselors for assistance with NBS program and development of a Kansas State Genetic Plan.

A second member of the follow-up program attended the tandem mass spectrometry (MS/MS) training at Duke University in April 2009.

The webpage section "Information for Parents" has been translated to Spanish and posted to the website. Parent letters and information sheets have also been translated and used with parent mailings regarding abnormal or unsatisfactory specimens.

The Practitioner's Manual continues to be updated on the website as necessary.

NBS follow-up staff remain active in the Heartland Genetics and Newborn Screening collaborative by serving as State Genetics Coordinator and advisory board member.

c. Plan for the Coming Year
Direct Services:

Continue last year's services.

Enabling Services:

Continue last year's services.

Infrastructure Building Services:

NBS follow-up staff will continue regular coordination meetings with the State public health laboratory staff. Quarterly meetings of the legislatively-mandated, NBS Advisory Council will continue to ensure coordination between the public and private sectors and to evaluate the program.

Through a contract with Envision Technology Partners, Inc , a new birth defects registry will be developed that will interface with the NBS and CSHCN data systems. Information systems will export birth certificate data into the new Birth Defects Registry. The registry will continue to receive and monitor legislatively-mandated reports submitted by hospitals, birthing centers, and physicians regarding children under age 5 with a primary diagnosis of congenital anomaly or birth defect. MCH epidemiologists will analyze birth defects data.

Staff will continue to work with KDHE IT staff to match vital demographic data with lab specimens through data linkages.

Contracts with certified genetic counselors will be updated to reflect the current status and needs of the NBS program.

NBS follow-up staff will provide regional trainings that will be available to all hospitals/facilities in the state that perform NBS. The trainings will include information on collection, lab processes and conditions identified through NBS. Continuing education will be available.

One staff member is in the process of completing the Kansas Public Health Certificate program and one member has applied to attend Sarah Lawrence Public Health Genetics/Genomics certification program.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	60	65	65	65	70
Annual Indicator	59.1	65.6	65.6	65.6	65.6
Numerator					
Denominator					
Data Source					National CSHCN 2005-2006. Estimate KS.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	70	75	75	75	75

Notes - 2008
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006.

Data for 2008 is not available. 2005-2006 data was used to pre-populate this performance measure. The wording of the two questions used to evaluate this outcome remained the same between 2001 and 2005-2006 National Children with Special Health Care Needs Survey and are therefore, comparable.

Notes - 2007
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measure. The wording of the two questions used to evaluate this outcome did not change; same as 2001. Indicator is comparable across survey years.

Notes - 2006
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06

The wording of the two questions used to evaluate this outcome did not change; same as 2001. Indicator is comparable across survey years.

a. Last Year's Accomplishments
Direct Health Care Services:

CSHCN staff continue to meet with families in the multi-disciplinary clinics to identify needs and

resources, and to find workable solutions.

Enabling Services:

Providing and organizing information in meaningful/useful formats, and enhancing the family's role within the health care team is support through the use of health care notebooks provided free of charge. CSHCN staff work with families in the development of treatment plans. Non-contracting CSHCN providers are contacted to expand and build the partnership between all programs.

CSHCN hired a bilingual staff to answer the MCH toll-free line and interpret for Spanish-speaking families calling the Bureau of Family Health programs. Additional language interpreter services are available using a national registry. CSHCN has two bilingual staff in the Kansas City catchment area to actively engage families in decision making and address cultural concerns.

Population-Based Services:

CSHCN Health Care Plans are reviewed annually and updated with family input and medical reports. Families in the "tiny-K "early intervention program (Part C of IDEA) are involved from the beginning in the development of the Individual Family Service Plan. Families also participate in the development of Individual Education Plans (IEP) for children ages 3-21. When families report difficulties in obtaining services they are referred to the Kansas Parent Training and Information Center and Families Together Inc. for peer support, education in the family/youth partnership role, and to support decision making skills.

A Family to Family Grant was awarded to Kansas this past year expanding their scope of training to include the family's role in health care partnerships and decision making.

Infrastructure Building Services:

CSHCN collaborated on the Family to Family grant that was awarded to Families Together, Inc. Families Together Inc. staff sponsors the Parent Advisory group for the CSHCN program and have been active in reviewing policies for the CSHCN program. A parent member of the advisory group attended the 2008 AMCHP meeting. CSHCN contracted with Families Together, Inc., the Parent Leadership Network, to strengthen youth/parents roles as decision makers and leaders. Youth schedules and interest in the topics presented for input were barriers to youth participation. Participants are financially supported to participate in activities that impact policy, programs and services to CYSHCN and their families. Family to family match was an avenue used to enhance the capacity of parents.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHCN staff meet with families at each multi-disciplinary clinic visit to assess and address family needs.	X	X	X	X
2. Treatment plans are reviewed at each clinic visit with youth and their family to assure understanding and agreement in the treatment plan.		X	X	X
3. Families help identify and choose service providers.	X	X	X	X
4. The MCH toll-free line is staffed by a bilingual person.		X		
5. Families serve on a Parent Advisory Committee.		X	X	X
6. Families and youth are financially supported to serve as advisors.		X	X	X
7. Educational materials promoting family/professional		X	X	X

partnerships are available in the multi-disciplinary clinics.				
8. Personal health care notebooks are made available to families.	X	X	X	X
9. Assure adequacy of bilingual services.				
10.				

b. Current Activities
Direct Services:

Families seen in a CSHCN sponsored specialty clinic are asked to complete a satisfaction survey that captures partnership levels, cultural competencies, and transition planning activities.

Enabling Services:

Families Together, Inc. and Kansas Youth Empowerment Academy collaborated on a grant application for the 2009 Integrated Community Systems Grant co-authored by CSHCN and The Kansas University Center on Developmental Disabilities. Notices to participate on state-level projects/initiatives are forward to the Families Together, Inc's. Director and Youth Empowerment Academy staff with encouragement to participate.

Population-Based Services:

Same as last year.

Infrastructure Building Services:

New family members were added to the Parent Advisory Committee. In-service training about the agency and families' expectations and overall advisory role was reviewed. Mission statement and bylaws are being updated to reflect the meaningful purpose of existence.

c. Plan for the Coming Year
Direct Health Care Services:

Data and responses from the family survey will be evaluated, shared, and discussed with the Parent Advisory Committee for potential program service(s) recommendations.

Enabling Services:

In partnership with families, CSHCN will expand the use of technology to improve timely exchange of information that is family centered and family directed. Updating Charter/By-laws to guide operations for the Parent Advisory Committee is being carried over from last years objectives. The advisory group will develop a plan to improve geographic parity, cultural competencies, and minority and youth representation.

Population-Based Services:

Family satisfaction survey data will be utilized at the MCHB Five Year Needs Assessment.

Hospital discharge teams will be targeted to provide copies of medical histories, in-hospital evaluations, and treatment plans to families at time of discharge. This was identified as a priority by the Part C Infant-Toddler early intervention team to promote positive family/professional relationships, timely sharing of information, and initiating interventions based on already available evaluations.

CSHCN continues to work with Part C of IDEA to accomplish this task. The practice of providing families with copies of medical records will also be a topic of discussion at the personal health history projects just getting underway in Kansas.

Infrastructure Building Services:

Due to budget limitations, we were unable to send a parent to AMCHP this year. We will continue to evaluate and implement strategies to engage youth as part of the advisory team.

The grant application submitted by CSHCN and the Kansas University Center on Developmental Disabilities includes a strong component on youth development supporting self awareness, self-management of healthcare needs within all aspects of daily living, and personal decision making. Youth and families will be engaged as partners in this grant process and will serve on the Advisory Council.

At the Five Year Needs Assessment, Kansas will review Title V/CSHCN policy and practices using data from the 2009 Family Satisfaction Survey, NSCHSNC data, and input from consumers and providers to expand family/professional partnerships and support family decision making opportunities at all levels.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	60	65	60	60	60
Annual Indicator	58.9	55.3	55.3	55.3	55.3
Numerator					
Denominator					
Data Source					National CSHCN 2005-2006. Estimate KS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	60	60	60	60

Notes - 2008
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006.

Data for 2008 is not available. 2005-2006 data was used to pre-populate this performance measure. Substantial additions, wording changes, and skip revisions between 2001 and 2005-2006 National Children with Special Health Care Needs Survey have occurred. This indicator is not comparable with pre 2005 data.

Notes - 2007
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measure. Substantial additions, wording changes, and skip pattern revisions were made in 2005-06 to the sets of questions used to construct the Care Coordination and Access to Referrals components of the medical home composite measure for this outcome. Indicator is not comparable across survey years.

Notes - 2006
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06

Substantial additions, wording changes, and skip pattern revisions were made in 2005-06 to the sets of questions used to construct the Care Coordination and Access to Referrals components of the medical home composite measure for this outcome. Indicator is not comparable across survey years.

a. Last Year's Accomplishments
Direct Health Care Services:

The CSHCN program authorized care for children eligible for treatment services when the child was seen by the primary care provider related to an eligible condition. The CSHCN program continued to identify and contract with new PCPs to expand medical home options.

Families of newborns with low birth weight and low APGAR scores or congenital birth defects, identified by the birth defects registry, were sent a postcard with information about available services, and to confirm they had a primary care provider. Families requesting additional information were contacted and given the requested information and assistance.

Enabling Services:

Modifications to the vendor contract specified that the PCP would receive a copy of the specialty provider report within two weeks of the specialty clinic appointment. Staff continued to work with the Oral Health coalition on concerns of dental access for all children and those with special health care needs. JJA waivers are used in Kansas to place physicians in underserved areas of the state.

The SCHIP or HealthWave XIX program changed policy and no longer required PCP referral to a specialist. A copy of the CSHCN generated health care plan was mailed to the Medicaid managed care programs. Monthly reports are compared to assure dual coverage is coordinated. In addition to contracted interpretation/translation services, the central CSHCN office hired an onsite bilingual person. The Farm Worker Migrant Health Program hired Low German-speaking interpreters who also contract with CSHCN to support family/professional partnerships and communication.

Population-Based Services:

Kansas Legislature defined Medical Home in statute and charged the Kansas Health Policy Authority (KHPA) to implement the program.

Infrastructure Building Services:

New computer software was connected to the state-wide immunization registry allowing physician access to immunizations records.

CSHCN requested feedback from the Kansas Child Adolescent Health Council (KCAHC), the Bureau of Family Health's physician advisory group. CSHCN participated in the Leadership Education in Neurodevelopmental and Related Disabilities (LEND) student training. LEND students were invited to the Bureau of Family Health to share information and exchange ideas future collaboration opportunities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Reports from the medical specialist are provided to the primary care physician and other providers identified by the family.		X	X	X
2. CSHCN authorizes follow-up services within the medical home related to the eligible health conditions.	X	X	X	X
3. Contracting PCP can access the state-wide immunization registry.	X	X	X	X
4. CSHCN authorization of services and health care plans developed with the family are shared with the managed health care programs.		X		X
5. CSHCN tracks medical home status of clients seen in specialty clinics and assists families to obtain a PCP.	X	X	X	X
6. Families who have children identified in the New Born Screening process are referred to CSHCN program for follow up services.	X	X	X	X
7.				
8.				
9.				
10.				

b. Current Activities
Direct Services:

Same as last year.

Enabling Services:

CSHCN is a stakeholder on the KHPA Medical Home Initiative. The initiative is charged to implement the Kansas law passed in 2008 defining a Medical Home. A companion to the Medical Home Initiative is the introduction and design of e-medical records and personal health histories.

The toll-free Make A Difference Information Network is formatted with new links to national, state, and community resources for both consumers and professionals. The program navigates providers and consumers to information enhancing comprehensive management coordination between the medical home and local service providers. The website allows viewers to go directly to 211 mapped community resources, health, education and workforce services for all ages by clicking on a specific topic listing. County specific resources are also highlighted.

Population-Based Services:

A survey of primary care providers (PCP) is being conducted to assess the level of timely

communication between specialty care providers and PCPs and co-management transition planning activities.

Infrastructure Building Services:

The CSHCN program is being connected with the Birth Defects Reporting System and will no longer be part of the KDHE WebIZ Immunization Registry. This change reduces the number of persons in the CSHCN database and minimizes data entry errors and/or possible client demographic information duplication.

c. Plan for the Coming Year
Direct Services:

Federal and State budget allocations will determine the scope of direct services that will be available.

Enabling Services:

Same as last year.

Population-based Services:

Data from the 2009 Physician Survey will be shared with contracting vendors during contract negotiations to support timely and comprehensive client services and co-management between specialty and primary care providers.

Infrastructure Building Services:

Results of performance measure outcomes will be included in the Five Year Needs Assessment. A new strategic plan for access and expanded services within a medical home will be developed in concert with Kansas Health Policy Authority's State-wide initiative supported by all medical domains, insurance and consumer groups.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	65	70	70	70	64
Annual Indicator	63.9	62.9	62.9	62.9	62.9
Numerator					
Denominator					
Data Source					National CSCHN 2005-2006. Estimate KS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a					

3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	64	64	68	68	68

Notes - 2008
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006.

Data for 2008 is not available. 2005-2006 data was used to pre-populate this performance measure. Indicators are comparable because no changes have occurred between 2001 and 2005-2006 National Children with Special Health Care Needs Survey.

Notes - 2007
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measure. Indicator is comparable across survey years (no changes; same as 2001).

Notes - 2006
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06

Indicator is comparable across survey years (no changes; same as 2001).

a. Last Year's Accomplishments
Direct Services:

Screening of social and emotional development is now a reimbursed component of the EPSDT assessment. Insurance status is checked at specialty clinic appointments and during the CSHCN renewal application process to support ongoing enrollment in eligible programs. Support is provided to complete the application process. Adding citizenship status to the CSHCN program application allowed staff to prescreen for Medicaid eligibility and streamline the CSHCN application process. The CSHCN program continued to be the sole source of coverage for undocumented persons with eligible health conditions and who meet financial guidelines.

Enabling Services:

Medicaid/SCHIP and CSHCH applications are written in English and Spanish. The Medicaid/SCHIP applications were labeled with the CSHCN name with instructions to figure spend down liability so families could receive maximum benefits. The Medicaid Clearinghouse liaison worked with the CSHCN program to resolve benefit concerns.

Population-Based Services:

The expanded newborn screening program made referrals to CSHCN for follow up services.

Infrastructure Building Services:

New contracting providers were added for eligible metabolic conditions. CSHCN program uses a sliding fee scale for metabolic conditions to minimize out-of-pocket charges. PKU formula was ordered through the CSHCN program allowing families with private insurance who fall within

established sliding fee scale guidelines access to discounted rates on products.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor Federal and State public insurance changes.		X	X	X
2. CSHCN tracks the insurance status on all children/youth seen in the CSHCN sponsored clinics and assists families to apply for eligible programs.	X	X	X	X
3. CSHCN coordinates with SCHIP/ Medicaid on eligibility determinations.		X		
4. CSHCN program staff work closely with Clearinghouse staff to resolve funding problems minimizing out of pocket charges.		X		
5. CSHCN assists families coordinate metabolic formula coverage with private insurance companies.		X		
6. Metabolic formula orders are routed through CSHCN for discounted rates.	X		X	
7. CSHCN authorizes eligible services with contracted providers that take the CSHNC rate of payment to avoid/minimize out of pocket expenses.	X	X	X	
8. CSHCN coordinates with private non-profit organizations to fund medically necessary treatments and equipment not otherwise covered.	X	X		X
9.				
10.				

b. Current Activities
Direct Services:

CSHCN will continue to monitor the number of persons/families and eligible conditions as a result of the expanded newborn screening program, and ensure the insurance status is assessed at specialty clinic appointments.

Enabling Services:

Same as last year.

Population-Based Services:

Same as last year.

Infrastructure Building Services:

CSHCN has been successful in bridging the transition period with two new Title XIX and SCHIP programs and forging new relationships during this adjustment phase.

c. Plan for the Coming Year
Direct Services:

Same as previous years.

Enabling Services:

Same as last year.

Population-Based Services:

Same as last year.

Infrastructure Building Services:

Kansas will continue to assess state and federal program agendas and benchmark services with other states to ensure the needs of Kansas families are met. Family support groups will continue to serve in advocacy and training roles. The Kansas Health Policy Authority continues to be the lead agency assigned to address access to insurance. Kansas Department of Health and Environment is a key partner addressing not only insurance coverage but access to services for those on public programs. CSHCN supports departmental leadership efforts while providing information to individuals and assists them in applying for available funding.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	70	75	75	75	95
Annual Indicator	70.9	92.5	92.5	92.5	92.5
Numerator					
Denominator					
Data Source					National CSHCN 2005-2006. Estimate KS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	95	99	99	99	99

Notes - 2008
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006.

Data for 2008 is not available. 2005-2006 data was used to pre-populate this performance measure. Significant changes have occurred between 2001 and 2005-2006 National Children with Special Health Care Needs Survey in placement, phrasing, and ordering of this question. Thus, this indicator is not comparable with pre 2005 data.

Notes - 2007

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measure. Significant revisions were made to the wording, ordering and placement of the question in the 2005-06 survey. Indicator is not comparable across survey years.

Notes - 2006
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06

Significant revisions were made to the wording, ordering and placement of the question in the 2005-06 survey. Indicator is not comparable across survey years.

a. Last Year's Accomplishments
Direct Health Care Services:

The CSHCN program supported services in the local communities by financially supporting outreach specialty clinics. Outreach clinics included pediatric cardiology, orthopedic, pediatric rheumatology, otolaryngology, audiology, and developmental pediatrics. An agreement with the Kansas State Department of Education funded Special Child Clinics. These clinics were held throughout the State with a multidisciplinary team based on each community's assessed needs.

Special Child Clinics assisted local teams in the diagnosis and treatment of conditions such as autism, developmental, and learning delays.

Enabling Services:

Interpretation services were provided for families. A bilingual Advanced Registered Nurse Practitioner, and a receptionist are on the multi-disciplinary team that serves the Kansas City catchment area. Transportation and other needed interpreter services are funded for specialty clinic appointments (not otherwise covered).

Kansas providers are expanding tele-medicine to connect local health providers to specialists. The new CSHCN data system interfaces with the following: Immunization Registry and Birth Defects Reporting System.

Population-Based Services:

The Kansas early intervention program, "Tiny K" provided services to children in a natural environment (child care center, home etc) and collaborated with CSHCN program for eligible services. The CSHCN program funded local follow-up screenings for the Sound Beginnings (Kansas Newborn Hearing Screening) program. The expanded New Born Screening program also referred to CSHCN for follow up services. This has helped establish seamless identification and interventions for CSHCN with services being authorized to nearest provider source.

Infrastructure Building Services:

CSHCN participated on the Oral Health, Sound Beginnings, and EPSDT Advisory teams. CSHCN and Part C of IDEA staff served on the Early Child Care and Early Education Advisory Committee.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach clinics to underserved areas are provided by CSHCN contractors.	X	X	X	X
2. CSHCN (ages 0-3) are referred to Part C Early Intervention networks in their communities.		X	X	X
3. CSHCN (ages 3-21) are referred to local school districts for Part B services in their communities.		X	X	X
4. Special Child Care Clinics are offered in local communities through an interagency agreement with the Kansas State Department of Education.	X	X	X	X
5. Interpreter services are covered for visits with local and specialty providers as needed.	X	X		
6. CSHCN staff work with local communities to identify needs for specialty outreach, care coordination and agency/programs.		X	X	X
7. The Make A Difference Information Network tool free line and website link consumers and professionals to resources and services.		X	X	X
8.				
9.				
10.				

b. Current Activities
Direct Services:

Same as last year.

Enabling Services:

The Make a Difference information toll-free line and website, link to the United Way's 211 mapped community resources, Kansas Department of Social and Rehabilitation Services' (SRS) resources by counties, Families Together, Inc., Area on Aging, Oral Health, Kansas State Board of Education/Special Education, Kansas Commission on Disability Concerns and other websites enhance awareness of community based resources and help the reviewer match resources to the identified need.

Population-Based Services:

Families interviewed for the 2005-2006 national CSHCN survey reported a 92.5 % response to community-based services being organized so they can use them easily. This reflects the efforts made to map community resources and provide families with local information and service(s) directories. An ongoing review and updates are completed to assure that this data is a valid reflection of the service delivery system.

Infrastructure Building Services:

The CSHCN data module on the Kansas Immunization Registry was reviewed and modifications were recommended. Marketing of the Make A Difference Information Network and trainings have been completed with SRS, Office of Oral Health, Area on Aging, Shared Vision for Youth, Kansas Department of Health and Environment - Bureau of Family Health, and Kansas State Board of Education.

c. Plan for the Coming Year
Direct Services:

Same as last year.

Enabling Services:

The CSHCN program will continue to support outreach specialty clinics as described last year. Health, pharmacy and other ancillary providers identified by families will be contacted to become a contracting provider. The CSHCN field office staff will continue to link families and service providers to resources.

Population-Based Services:

The lack of services in rural and frontier locations is compounded with a growing and diverse population seeking work in these regions. Strategic planning during the upcoming Five Year Needs Assessment will include community leaders who have established a trusted working relationship with these new residents and can identify resources that are culturally suitable.

Infrastructure Building Services:

The effort of the Kansas Health Policy Authority to implement the Medical Home is a statewide initiative to best utilize limited resources and provide services in the community setting. CSHCN supports this agenda and will incorporate state-wide policy in the strategic planning sessions for the Five Year Needs Assessment.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	5	15	6.3	6.3	53
Annual Indicator	5.8	50.3	50.3	50.3	50.3
Numerator					
Denominator					
Data Source					National CSHCN 2005-2006. Estimate KS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	53	55	55	55	55

Notes - 2008
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with

Special Health Care Needs. 2005–2006.

Data for 2008 is not available. 2005-2006 data was used to pre-populate this performance measure. Substantial alterations, additions, and difference in skip pattern have occurred between 2001 and 2005-2006 National Children with Special Health Care in these questions. Thus, this indicator is not comparable with pre 2005 data.

Notes - 2007
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measure. In 2005-06, substantial changes and additions were made to the set of questions and skip patterns used for this outcome. Two questions were removed and several new questions were added to address concepts not measured in 2001. Indicator is not comparable across survey years.

Notes - 2006
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06

In 2005-06, substantial changes and additions were made to the set of questions and skip patterns used for this outcome. Two questions were removed and several new questions were added to address concepts not measured in 2001. Indicator is not comparable across survey years.

a. Last Year's Accomplishments
Direct Services:

CSHCN staff met with families at specialty clinics sharing resources, providing anticipatory guidelines, and communicating with community supports as approved by families.

Enabling Services:

The CSHCN program has multi-disciplinary transition clinics for older youth in order to address transition issues (Cleft lip/palate, Cerebral Palsy, Cystic Fibrosis and Spinal Cord).

CSHCN staff continue to use the timeline that was developed by the Children Have Opportunities in Inclusive Communities Environments and Schools (CHOICES). The CHOICES Project assists families with early transition issues from toddler age through adolescence. Some topics discussed at CSHCN specialty clinics include: guardianship at age 18 and alternative options, adult medical care after the child ages out of pediatric services; SSI/insurance/ Medicaid coverage after age 21; appropriate independent living options; post high-school education; and a referral to Rehabilitation Services (formally Vocational Rehabilitation), if appropriate.

A transition toolkits in English and Spanish are located in the waiting areas of the specialty clinics to encourage families, at any age, to have discussions about transition planning. A list linking to web based transition tools and resources was provided as a take-home directory.

Population-Based Services:

The Kansas State Department of Education (KSDE), in coordination with other state programs, conducted the annual transition conference. Families Together, Inc. also provided transition conferences in targeted regions throughout the state. CSHCN staff participated in, and presented

at, these events.

The Youth Empowerment Academy conducted a week long "Youth Leadership Forum" allowing YSHCN to experience college campus life, meet with legislative members and develop action plans to meet their individual goals and objectives. These programs allowed YSHCN to network with other YSHCN and strengthen bonds for future youth involvement in policy and advocacy events.

CSHCN supported "Youth Leadership Forum" and was a stakeholder in the Initiative to implement Medical Homes in Kansas. Addressing transition barriers for youth transitioning from pediatric to adult service providers is one of the Initiative's components.

Infrastructure Building Services:

Contract language was modified to include transition planning performance measures in vendor contracts.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Transition clinics for Cystic Fibrosis, Cerebral Palsy, Cleft Lip/ Palate and Spinal Cord are held regularly for the older youth.	X	X	X	X
2. Education and Families Together, Inc conduct transition workshops for professionals and families. CSHCN staff provide input and are speakers at these events.	X	X	X	X
3. CSHCN staff participate in local, regional, state and national workshops, to promote inclusion and increase awareness of the needs of this population.		X	X	X
4. CSHCN staff represents the Secretary of Kansas Department of Health and Environment on the Kansas Council on Disability Concerns and Kansas Council on Developmental Disabilities.			X	X
5. Transition information, notebooks, and internet links are shared with families and professionals to support transition planning.	X	X	X	X
6. Kansas has utilized TA and handouts from the National Healthy and Ready to Work Center. A Kansas specific transition toolkit is distributed at clinic visits, conferences & family support programs.		X	X	X
7. Families Together, Inc. and the Parent Advisory Council provide input on current and future CSHCN transition efforts.		X	X	X
8.				
9.				
10.				

b. Current Activities
Direct Services:

Same as last year.

Enabling Services:

Continue to support transition planning efforts in the specialty clinics

Population-Based Services:

A family survey containing questions about transition planning and information needed to address transition topics is being conducted.

Infrastructure Building Services:

In addition to last years activities, CSHCN is a stakeholder on the Kansas Health Policy Authority's Medical Home Initiative and Electronic Medical Record/ Personal Health Information Implementation that started in the later part of the year.

CSHCN staff attended the Regional Shared Vision for Youth (SVY) peer to peer dialogue and planning session. CSHCN staff has taken a supportive role to partners new to the SVY.

Kansas applied for and was awarded the 2009 Integrated Community Systems grant that includes engaging and supporting youth activities associated with effective partnerships with providers, knowledge and skill building to support transition objectives within a medical home, education, community living, and work.

c. Plan for the Coming Year
Direct Services:

Same a last year.

Enabling Services:

CSHCN will review current clinic practices based upon the Family survey results and stakeholder recommendations, address indentified service gaps and build upon clinic strengths. In addition to last year's activities, CSHCN staff will continue to support expanded activities of Families Together, Inc. The Family to Family grant expands their current roles/expertise in the education arena to include health community partners and train/educate families about their roles in these partnership roles.

Population-Based Services:

Continue from previous years.

Infrastructure Building Services:

Participate in a school career fairs that highlight the strengths of each program and design a model to be used in other regions.

CSHCN staff remain active stakeholders in the Medical Home and e-personal health record discussions currently in the research and design phases.

We were awarded the Integrated Community Systems for Youth with Special Health Care Needs Grant. Goals of this grant application include addressing transition to adulthood by incorporating into practice transition supports for youth/young adults with special health care needs.

The State's transition priority will be reviewed at the MCHB Title V Needs Assessment meeting. We anticipate that the expanded data collection and evaluation practices and the enhanced collaborative partnerships being strengthened the past five years will likely result in the continued support of this state priority.

We are changing our name from Children with Special Health Care Needs to Children and Youth with Special Health Care Needs to more accurately reflect the target population that is served by our program.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	80	82	82	89	90
Annual Indicator	80.6	87.5	83.6	83.3	83.3
Numerator					
Denominator					
Data Source					CDC National Immunization Survey 2007--KS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	91	91	91

Notes - 2008
DATA SOURCE: Centers for Disease Control and Prevention. National Center for Immunization and Respiratory Diseases. Vaccines and Immunization. US, National Immunization Survey, Q1/2007-Q4/2007. Estimated vaccination coverage with individual vaccines and selected vaccination series among children 19-35 months of age by state and local area. Table located on the web at http://www.cdc.gov/vaccines/stats-surv/nis/tables/07/tab02_antigen_iap.xls

Data for 2008 is not available. 2007 data was used to pre-populate this performance measure. National Immunization Survey Rates for DTP4: Polio3:MMR1 combination are reported here. In Kansas, Haemophilus Influenza type B is not required for school entry. For school year 2008-2009, Hepatitis B (3 doses) and varicella (1 dose) are required for all children in kindergarten through grade 5.

Notes - 2007
DATA SOURCE: Centers for Disease Control and Prevention. National Center for Immunization and Respiratory Diseases. Vaccines and Immunization. US, National Immunization Survey, Q1/2007-Q4/2007. Estimated vaccination coverage with individual vaccines and selected vaccination series among children 19-35 months of age by state and local area. Table located on the web at http://www.cdc.gov/vaccines/stats-surv/nis/tables/07/tab02_antigen_iap.xls

National Immunization Survey Rates for DTP4: Polio3:MMR1 combination are reported here. In Kansas, Haemophilus Influenza type B is not required for school entry. For school year 2007-2008, Hepatitis B (3 doses) and varicella (1 dose) are required for all children in kindergarten through grade 3.

Notes - 2006
Data Source: Estimated vaccination coverage with individual vaccines and selected vaccination series among children 19-35 months of age by state and local area. Table located on the web at http://www.cdc.gov/vaccines/stats-surv/nis/tables/06/tab03_antigen_state.xls

National Immunization Survey Rates for DTP4: Polio3:MMR1 combination are reported here. In Kansas, Haemophilus Influenza type B is not required for school entry. For school year 2006-2007, Hepatitis B and one dose of varicella are required for kindergarten, first and second grade entry.

a. Last Year's Accomplishments
The Haemophilus Influenza type B, Pneumococcal Conjugate and Hepatitis A is not required for school entry, but is required for a child < 5 years of age in a preschool or child care operated by a school. For school year 2009-2010, Hepatitis B (3 doses) and Varicella (2 doses) are required for all children in kindergarten through grade 9. The following vaccines are recommended for 12 - 15 month olds by the Kansas Immunization Program (KIP): DTP4: Polio3: MMR1 combination. According to the National Immunization Survey, 2007, the percentage of Kansas's children 19-35 months old for 4:3:1:3 (DTP4: Polio3: MMR1: HepB3) is 83.6 percent.

Direct Services:

Agreements between Local Health Departments (LHD)/Rural Health Clinics (RHC)/Federally Qualified health Centers (FQHC) allowed vaccination of children with VFC vaccine.

Kansas Immunization Program (KIP) increased number of birthing hospitals in Vaccine for Childen (VFC) program to assure first dose of hepatitis B is given within 24 hours of birth.

Enabling Services:

School nurses collaborated with local health departments (LHDs) to conduct immunization surveillance/notification of needed vaccines as well as school-based vaccine clinics.

Healthy Start Home Visitors (HSHV) provided immunization information/referrals to families as outreach/family support services.

Population-Based Services:

Congratulatory birth cards signed by the Governor were sent to all new parents featuring an immunization schedule and reminder to contact their health providers to protect their new baby with vaccinations. 44,000 cards were sent out. The Birth Card Project Partnership is a project between the KIP, Hallmark and the Governor's Office.

Adolescent/adult vaccine information was provided to public health nurses promoting vaccinations to protect infants/young children from exposure to preventable diseases.

KIP promoted and facilitated school influenza vaccination clinics and an evaluation of the feasibility of school-based immunization of students by Immunize Kansas Kids (with report to be presented to the legislature January of 2009).

Infrastructure Building Services:

KSWebIZ partnered with Medicaid conducting outreach designed to increase beneficiary immunization rates, including the "Immunize and Win a Prize" program continued as a parent incentive to have children using VFC fully vaccinated by age 2. A Kansas Foundation for Medical Care Survey shows immunization rates have increased from 2003 from 56 to 79% for

HealthConnect Kansas, a primary care case management focused primarily on Social Security Income (SSI) and MediKan disabled beneficiaries, 48 to 73% for HealthWave-19 (Medicaid) children and 49 to 82.4% for HealthWave-21 (SCHIP) children.

KIPs Immunization Registry (KSWebIZ) enrolled 63 new provider sites to total 202 sites (123 private providers, 79 local health departments). A June 2008 Kansas Health Institute (KHI) report, "Immunizing Children in the Medical Home -- Does it Make a Difference?" suggests improving numbers of VFC providers and access to private clinics, particularly in urban areas, could improve immunization coverage rates for children ages 19 -- 35 months.

KIP refined a bi-directional electronic interface capacity with 26 LHD using other immunization data management systems allowing for data exchange with KSWebIZ.

KSWebIZ launched school module piloting the system with 29 school nurses with an additional 60-90 schools targeted for enrollment by June 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Schools/public health agencies will provide education on age-appropriate immunizations to parents at well-child screening, enrollment into child care/school age programs, and other points of parent contact using educational materials provided by the		X	X	X
2. Providers of immunizations will receive technical assistance/consultation on questions regarding immunizations, specific vaccines and vaccine service from the Kansas Immunization Program.			X	X
3. Promote provider partnerships to maintain high levels of immunization for all children/youth through delegation agreements to administer vaccines.				X
4. Use Medicaid outreach projects for counties with low immunization rates to ascertain children's immunization status / referrals through all WIC clinics statewide.	X	X	X	X
5. Expand development / use of KSWebIZ to maintain immunization records in medical homes/school settings utilizing interfaces with other data sources, including Medicaid.				X
6. HSHV provides immunization education and refers families to local providers to obtain immunizations for their children at each home visit / point of parent contact. Expand development / use of KSWebIZ to maintain immunization records in medical homes		X		X
7. Private providers will be offered training sponsored by the Kansas Immunization Program to promote use of KSWebIZ.	X			X
8. Birthing hospitals will provide birth dose of hepatitis B as VFC provider.			X	X
9. Identify strategies to provide vaccine education to school populations supporting school-based immunization clinics collaborating with medical homes and local health departments.	X		X	X
10.				

b. Current Activities

Immunize Kansas Kids (IKK) released report, Feasibility of a School-Based Influenza Vaccination Program in Kansas (2009).

KIP receives award at the National Immunization Conference March 2009 for second most improved immunization rates from 2004--2007.

Direct Services:

KWIC interface development for KSWebIZ implemented April 2009.

Enabling Services:

Changes in state leadership May 2009 creates a temporary discontinuance of the Birth Card Project for 6-8 weeks while cards are updated/printed with new Governor's name. The program will resume when KIP receives the new cards.

School nurses notify parents regarding needed school-age vaccines.

Population-Based Services:

KAR 28-1-20 amended to include requirements for children in licensed child care facilities, registered family day care homes and early childhood programs operated by schools. Updating and combining immunization requirements for school entry provides continuity and a single regulation for immunization requirements for children.

Infrastructure Building Services:

As of May, 132 private/85 public providers are on KSWebIZ with 84 LHD out of 105 counties using KSWebIZ. 70 school districts/151 school nurses are using the school module with additional school districts/nurses to be added totaling 200 school nurses on KSWebIZ by the end of 2009.

KIP is projected to receive $2,064,374 in ARRA funds. The funds were to target varicella for middle-school students, but may be used for flu vaccine/vulnerable populations.

c. Plan for the Coming Year

Direct Services:

If the project plan is approved by CDC, LHDs will have access to increased supplies of Varicella vaccine to provide immunizations to underinsured students prior to the 2010-2011 school year. The anticipated funding will purchase approximately 33,000 doses of Varicella vaccine.

Birthing centers and hospitals will provide Hepatitis B vaccination to all babies born in this setting.

Hepatitis B (3 doses) and Varicella (2 doses) will be required for all students through grade 9 for the 2009-2010 school year in an effort to expedite the coverage of the school population for protection against the two diseases. New immunization requirements will be in effect for early childhood programs operated by schools.

With change in the regulations for required vaccinations for preschools operated by schools / school entry, additional vaccines will be required: Varicella (2 doses), Hepatitis A, Hib and Pneumococcal conjugate (PCV7).

The partnership with KIP/WIC clinics selected to expand the immunization program into WIC clinics will be established and ongoing.

KSWebIZ will generate reminders to parents regarding vaccine due dates for their children.

Enabling Services

The Governor's Birth Card Project, as well as "Immunize and Win A Prize" as a parent incentive for children participating in VFC will continue, as well as the incentive program for parents in the Medicaid program to reward parents who complete age-appropriate immunizations when their child is 2 years of age.

HSHV will continue providing education to families about the importance of immunization and immunization schedules.

School nurses will notify parents regarding vaccines needed by their school-age children.

Population-Based Services:

KIP will continue to enroll birthing hospitals as VFC providers and will monitor birthing hospitals to assure first dose of Hepatitis B is given within 24 hours of birth.

Infrastructure Building Services:

Additional private and public providers will be added to Kansas WebIZ. Additional school districts/nurses to be added as Kansas WebIZ users.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	20	19	19	18	18
Annual Indicator	20.4	19.6	19.5	21.7	21.7
Numerator	1179	1135	1152	1273	1273
Denominator	57850	57812	59155	58780	58780
Data Source					Kansas Vital Statistics, 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	20	20	20	20	20

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Fall 2009.

Notes - 2007
Data Source:
Numerator = Birth certificate (resident) data, 2007, Center for Health & Environmental Statistics,

KDHE
Denominator = U.S. Census estimates (Bridged-Race Vintage data set), 2007

Notes - 2006
Data Source:
Numerator = Birth certificate (resident) data, 2006, Center for Health & Environmental Statistics, KDHE
Denominator = U.S. Census estimates (Bridged-Race Vintage data set), 2006

a. Last Year's Accomplishments
In Kansas, 2007, the teen birth rate (ages 15-17) was 21.7 per 1,000 females. This was 11.2% higher than 2006 (19.5 per 1,000). The 2007 rate is significantly higher than the 2006 rate (i.e., the difference between the 2007 and 2006 rates is statistically significant at the 95% confidence level.)

In 2006 (the most recent year national data for this age group is available); the birth rate for Kansas teenagers 15-17 years (19.5 per 1,000) was 11.5% lower than the national rate (22.0 per 1,000).

For the years 2003-2007, there is no statistically significant increasing or decreasing trend in teen births ages 15-17. However, over the 10 year period (1998-2007), there is a significantly decreasing trend ($p < 0.05$) in Kansas teen birth rate for this age group.

Direct Services:

Teen Pregnancy Case Management (TPCM) was provided to Medicaid eligible pregnant or parenting adolescents (up to age 21) in collaboration Kansas Health Policy Authority (KHPA). The project's goal is to reduce negative consequences of teenage pregnancy, increase self sufficiency, and delay future pregnancies until education and training goals are met.

MCH and Kansas Title X Family Planning (FP) program staff worked closely to provide STD testing/counseling as a routine part of client initial & annual FP clinic visits. The FP program has contractual relationships with 58 FP agencies located in 75 of KS 105 counties that screen all women 24 years of age or younger for STDs and continue to provide developmentally appropriate services to adolescents, including the provision of direct services to sexually active adolescents.

The KS HIV/STD Program and FP have increased their STD screening efforts therefore finding more cases of Chlamydia. This may account for the rise in KS Chlamydia in adolescents reported in Health Status Indicator # 05A.

Enabling Services:

Kansas continued the Abstinence Only Education (Ab Ed) program under Section 510 of Title V of the Social Security Act. In 2006, Kansas had 9 projects providing education and collecting data. Training was provided using curricula for "Choosing the Best" and the "Quinceanera" program.

Population-Based Services:

School and community based education was provided through the Community-Based Teen Pregnancy Reduction Projects (CBTPRP). Education targeted teens to help recognize the value of postponing sexual intercourse and provided education on pregnancy prevention.

MCH adolescent health staff partnered with Kansas State Dept. of Education (KSDE) and the other Region VII states to provide an educational conference on HIV/AIDS/STDs for teachers and nurses. There were 252 participants that work with youth from 18 states in attendance.

Infrastructure Building Services:

Kansas completed the first year of evidence based, community-based teen pregnancy reduction grants. Seven grants were provided to areas with high teen pregnancy rates and disparate populations. The Kansas team that attended the AMCHP/CityMatCH Teen Pregnancy Prevention Roundtable and Training continued to receive technical assistance using evidence-based teen pregnancy prevention (TPP) strategies and worked on refining the curricula implementation and evaluation processes.

MCH staff partnered with the Kansas Department of Social and Rehabilitation Services (SRS) to strengthen foster care systems and together the agencies provided a conference on fatherhood.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to provide family planning and STD prevention/treatment services to adolescents.	X	X	X	
2. Develop and promote use of evidence-based teen pregnancy prevention programs using principles from AMCHP and CityMatCH roundtable training on TPR.		X	X	X
3. Continue work with the Reconvene team on developing a youth advisory council addressing health disparities in STD screening and treatment.		X		X
4. Collaborate with KSDE and other states to offer a regional training on HIV/STD/AIDs education and prevention.		X	X	X
5. Continue to serve on a SRS Kansas Child Welfare Quality Improvement Committee to improve the permanency of teens in the foster care systems that are pregnant or parenting.		X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Direct Services:

The TPCM projects provide case management to eligible adolescents.

Kansas Title X Family Planning (FP) program efforts continue.

The STD Section of KDHE, currently has 11 Disease Intervention Specialists (DIS) strategically placed in the geographic areas of highest morbidity across the state. The STD Section has profiles on MySpace, Facebook, and Twitter to reach adolescents and updates their website to provide both teens and providers with relevant information on Chlamydia.

Enabling Services:

KSDE and MCH staff continue to collaborate on AIDS/HIV/STD education for teachers and nurses.

KSDE provides Sexuality ABCs (Abstinence, Birth Control and Condoms) Training through

Rucker's University e-College for the Reconvene team members (listed under Infrastructure Building).

Population-Based Services:

The 7 Community-Based Teen Pregnancy Reduction Project (CBTPRP) use evidence based programs.

STD and teen pregnancy risk reduction along with teen pregnancy management in the school environment is presented at the Annual Statewide Summer Conference for Kansas School Nurses.

Infrastructure Building Services:

All TPP program, Ab Ed and TPCM grantees receive grant writing training.

A team comprised of KSDE's HIV/AIDS Educator and Coordinated School Health staff and KDHE's Adolescent Health Consultant, and HIV prevention & STD Prevention Director attend the Reconvene session to increase capacity around HIV, STD, and TPP. The team is working on developing a youth advisory counci

c. Plan for the Coming Year
Direct Services:

The TPCM and FP programs will continue culturally-competent, comprehensive services to teens with emphasis on inclusion of both females and males.

Enabling Services:

KDHE staff will continue to support evidence based TPP programs and FP and STD Program efforts to reduce teen pregnancy and STDs.

Population-Based Services:

The community-based teen pregnancy prevention program will continue to evaluate the effectiveness of individual projects.

MCH will continue collaborations with KSDE to provide training on adolescent health issues and continue to provide school nurse/MCH education and treatment.

Kansas did not reapply for federal funding for the Abstinence Education Program. Kansas' program will operate through June 30, 2008. Most programs will continue on local and alternate funding.

Infrastructure Building Services:

The participants in the Reconvene Meeting will continue to collaborate and implement the State plan to decrease STDs and teen pregnancy.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	50	36	36	37	40
Annual Indicator	34.2	34.2	34.2	38.2	38.2
Numerator	11485	11485	11485	13176	13176
Denominator	33558	33558	33558	34506	34506
Data Source					KDHE. Smiles Across Kansas: 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	40	45	45	45	45

Notes - 2008
Data Source: KDHE. Office of Oral Health. Smiles Across Kansas: 2007 Update - unpublished weighted data.

Data for 2008 is not available. 2007 data was used to pre-populate this performance measure.

Notes - 2007
Data Source: Smiles Across Kansas: 2007 Update - unpublished weighted data.

Notes - 2006
Data Source: Smiles Across Kansas 2004: The Oral Health of Kansas Children

a. Last Year's Accomplishments
Direct Health Care Services:

Kansas does not have a State-sponsored program to directly place dental sealants on children's teeth.

Enabling Services:

The Office of Oral Health provides some funding for a school-based dental sealant project in a community dental "safety-net" clinic. The project is located in the Flint Hills Community Health Center catchment area and provides sealants for second and sixth graders in school districts in Lyon, Chase, Greenwood and Osage Counties who are dentally underserved.

Kansas has expanded its workforce by creating dental hubs and utilizing community-based "Extended Care Permit" dental hygienists to ensure that prevention services are brought to populations less able to access dental services in traditional office or clinics. The Kansas' State Primary Care Association and the Kansas Association for the Medically Underserved (KAMU) supports and collaborates with regional geographically diverse "dental hubs" operated by safety-net clinics. These are staffed by at least two dentists in a central underserved location, with spokes of care (Extended Care Permit dental hygienists) to satellite sites. The hubs focus on providing preventive, emergency and restorative dental services to the underserved. The Extended Care Permit dental hygienists provide preventive services with portable equipment by traveling to a neighboring community, nursing home or school. In 2007 the Kansas Legislature allocated for the dental hub concept as a solution to rural access, and private foundations agreed

to match state funds. KAMU has requested more funds in the 2010 session.

Kansas has attempted to extend oral health services to underserved populations by utilizing other health care personnel to do oral health education and prevention. Grant funding from United Methodist Health Ministries and REACH Healthcare Foundation has provided for two part-time staff (Registered Dental Hygienists) as Professional Outreach Coordinators, providing physician's offices training on the application of fluoride varnish at well-baby exams. The purpose of this initiative is: to prevent early childhood caries (ECC) through: (1) targeted early screening, (2) oral health education of caregivers, (3) application of a fluoride varnish to primary teeth if necessary, and (4) proper referral to a dentist if appropriate for care. The Kansas Medicaid program will reimburse medical providers for fluoride varnish treatments done in their offices up to three times a year.

Infrastructure Building Services:

The Office of Oral Health continues to collaborate with other agencies to support the dental benefit expansion for: HCBS Head Injured (HI) -- individuals age 16 and over who have had a traumatic injury to the brain; HCBS Mental Retardation/ Developmental Disabilities (MR/DD) Individuals age 5 and over who are mentally retarded or developmentally disabled; HCBS Physically Disabled (PD) Individuals age 16 and over who are physically disabled and need personal assistance with everyday tasks; HCBS Children with Severe Emotional Disturbance (SED) Individuals under the age of 21 who meet the severely emotionally disturbed criteria; HCBS Technology Assisted (TA): Individuals under the age of 18 who are dependent on mechanical ventilators or need intravenous support. Prior to this expansion of services, adults on Medicaid were only eligible for emergency dental services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide fluoride varnish training and oral health education to non-dental professionals.		X		X
2. Establish school oral health screenings and referrals.		X	X	X
3. Provide consultation and technical assistance to school based dental sealant project.		X		X
4. Support and provide technical assistance for the Medicaid dental benefit expansion waivers				X
5. Provide leadership to the Oral Health Kansas Coalition.				X
6. Provide leadership to the Kansas Public Health Association Board Oral Health Section.				X
7. Encourage a “dental home”.		X		X
8. Support increased public-private partnerships between schools, local public health departments and private practice dentists.		X		X
9. Collaborate with and support safety-net clinic “Dental Hubs”.				X
10. Targeted education and outreach to families to improve the oral health of children across Kansas.		X	X	X

b. Current Activities
Enabling Services:

In May a meeting was held to address the oral health of children with special health care needs. Approximately 75 parents, KDHE staff, medical and dental professionals attended.

A dental screening initiative is being piloted with more than 50,000 K-12 children to determine if they have treated or untreated decay, or sealants. This data will be provided to school nurses at their annual conference in July and analyzed for future policymaking and program planning.

With support from MCH state systems grant the Oral Health Kansas (OHK) coalition and OOH produced an online training course, "Healthy Smiles for Children and Youth with Special Health Care Needs" (http://www.kdheks.gov/ohi/cyshcn.htm#train). A poster was presented at the AAP PEDS 21 Conference. The content is incentivized for dental, medical staff, therapists, caregivers, and teachers who may receive 2 free CEUs.

Infrastructure Building:

KDHE OOH and OHK released the 2009 "Keep Kansas Smiling" Report Card. The grade improved from a "D+" in 2003 to a "B" in 2008 (http://www.kdheks.gov/ohi/download/Kansas_Oral_Health_Report_Card_2008.pdf). The project will raise awareness in supporting policies and programs that integrates oral health with overall health care and provide valuable information for future planning, resource development, and evaluation.

A workforce survey supported by a HRSA grant was sent to all dentists and ECP dental hygienists asking about practice patterns and future needs.

c. Plan for the Coming Year

Next year the dental screening initiative will be open to all schools across the state to participate and provide a more comprehensive oral health surveillance system.

The Health Resources and Services Administration awarded the Office of Oral Health a Health Professions grant to study the capacity of Kansas' dental workforce and gather community input on dental recruitment. This proposal will create a Kansas Dental Professional Recruitment Center that will bring together key oral health policy makers to form a Dental Workforce Cabinet. The Cabinet will decide Kansas workforce policy and fund locally initiated oral health access projects. This project will be supervised by the University Of Kansas Medical Center (KUMC) Research Institute. Community planning was held in April and May of 2009 in geographically diverse sites across Kansas. These meetings included focus groups and interviews with key oral health advocates. A unified final report of both the capacity data and the strategic planning will be complete and provided to HRSA in the summer of 2009, and will be utilized in the design of the Recruitment Center.

In 2009-2010 the Dental Workforce Cabinet will direct the activities of the Recruitment Center staff and make collaborative decisions on workforce policy. Members of the Cabinet will be responsible for reviewing current research and participating in program and policy discussions. The Cabinet will provide a forum for discussion of some of the more controversial workforce issues, and will allow Kansas to come to consensus around practical solutions.

The State oral health website (http://www.kdheks.gov/ohi) is consistently updated to keep stakeholders informed of the ongoing activities and oral health information. The Office of Oral Health continues to provide oral health training, technical consultation, and educational materials.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	5	5	4	5.5	3.8
Annual Indicator	5.1	5.9	4.0	3.7	3.7
Numerator	29	33	23	21	21
Denominator	564421	555339	574097	575333	575333
Data Source					Kansas Vital Statistics, 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3.6	3.6	3.6	3.6	3.6

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Fall 2009.

Notes - 2007
Data Source:
Numerator = Death certificate (resident) data, 2007, Center for Health & Environmental Statistics, KDHE
Denominator = U.S. Census estimates (Bridged-Race Vintage data set), 2007

Notes - 2006
Data Source:
Numerator = Death certificate (resident) data, 2006, Center for Health & Environmental Statistics, KDHE
Denominator = U.S. Census estimates (Bridged-Race Vintage data set), 2006

a. Last Year's Accomplishments
In 2007, the mortality rate for children ages <= 14 as a result of unintentional injury--motor vehicle crash was 3.7/100,000 children, 9.0% lower than in 2006 (4.0). Over the ten year period (1998-2007), there is a significant decreasing trend ($p<0.05$) detected in the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes in Kansas.

In the 2007 Kansas Traffic Accident Facts Book, there were 113 child pedestrians 1-14 years involved in accidents with no deaths, and 98 pedal cyclists age 1-14 years involved in accidents with no deaths.

According to the 2008 Annual Report (2006 Data) of the Kansas State Child Death Review Board (SCDRB), 2006 trends were consistent with the previous year data, particularly in relation to the Unintentional Injury - Motor Vehicle Crash category. As in every year since the inception of the SCDRB, the majority of children dying in MVC were not properly restrained. In 2008, 75% of children <= 14 was in child restraints. This is attributable to the passage of a booster seat law several years ago and the 2007 Legislature's decision to make failure to wear a seat belt or restraint by those under age 18 a primary violation meaning that police can pull a car over for that reason alone (2009 KDOT Report).

SAFE KIDS Kansas, Inc. is a nonprofit Coalition of over sixty statewide/regional organizations/businesses, including local MCH programs/partners, dedicated to preventing accidental injuries to Kansas children ages 0-14. SAFE KIDS is affiliated with the SAFE KIDS Worldwide, providing resources to local coalitions/chapters and annually adopts a policy platform and policy priorities to influence the laws, regulations and institutional policies that affect childhood safety and increase funding support for injury programs and research.

Direct Services:

SAFE KIDS coordinated with the Kansas Traffic Safety Resource Office (KTSRO)/local communities for Child Passenger Safety (CPS) training/inspection/provision of car seats providing education/resources. 1,300 child passenger safety seats were donated to a number of child passenger safety fitting stations with 125 agencies statewide given opportunities to request child passenger safety seats. Each of the agencies has a currently certified child passenger safety technician on staff.

Enabling Services:

Of the 108 CPS stations in Kansas, 31 are in local health departments (LHD). Some sites had available multi-lingual/Spanish-speaking technicians, services for the hearing impaired, and safety technicians who are trained on transporting children with special health needs (CSHCN).

MCH staff and Healthy Start Home Visitors (HSHV) continued outreach and family support to provide injury prevention information / education, including current laws, correct use/installation of car seats, booster seats and seat belts.

Population-Based Services:

MCH staff continued to inform families with new babies of the Child Passenger Safety Seat Act, KSA 8-1344, collaborating with community SAFE KIDS coalitions and the Kansas Safety Belt Education Office (KSBEO) to provide resources for CPS seats/seat belt use, and injury prevention education.

SAFE KIDS continued participating in a new national initiative, "Spot the Tot" which provides education/demonstrations to parents and children regarding safety in and around cars, including dangers of back over injuries and children left alone in vehicles.

The Legislature first considered a comprehensive graduated drivers licensing (GDL) policy (SB 294) in 2007 and again in 2008. During both sessions, the proposal was approved by the Senate, but was not brought before the full House for consideration.

Infrastructure Building Services:

The Spring MCH Orientation session included opportunities to inform new MCH staff about issues related to child safety.

In July 2008, a primary teen seat belt law was enacted. This law, based upon results achieved in other states, permits law enforcement officials to stop and issue citations to unbelted teen drivers or teen passengers without the requirement of a second infraction.

MCH staff collaborated with KDHE Office of Health Promotion (OHP) SAFE KIDS and Emergency Medical Services for Children (EMS-C) coalitions coordinating pediatric injury treatment/prevention educational programs across the state. The 2008 school nurse summer conference offered a post conference training, School Nurse Emergency Services for Children (SNEMS-C), attended by 60 school nurse.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaboration with the Kansas Dept of Transportation data collection to target injury prevention efforts to match community needs.			X	X
2. Participation in the Emergency Medical Services for Children Coalition to assist in coordination of pediatric injury, prevention educational programs targeting community level child health providers and school nurses.			X	X
3. Participation in the Kansas SAFE KIDS Coalition.			X	X
4. State Child Death Review Board analyses of deaths of children ages 1-14 that are involved in motor vehicle crashes.				X
5. Legislation supporting Graduated Driver's Licensing and primary seatbelt restraint law.			X	X
6. Promote training of MCH staff, including Healthy Start Home Visitors (HSHV), as child passenger seat technicians in all counties with distribution of car seats at no cost or low-cost.	X	X		X
7. Provide local health departments' with resources to assist in evaluation of local injury data assessment, and provide education and resources to reduce the motor vehicle unintentional injury rate through annual MCH Orientation and monthly ZIPS newsle				X
8. MCH staff and HSHV provide outreach, education, and instruction to families with infants and young children on importance of proper Child Passenger Safety and new Graduated Driver's Licensing legislation related to restraint of children birth through		X	X	X
9. Encourage community collaboration to seek out resources to assist in injury prevention programs such as Cycle Smart, Walk This Way, Spot the Tot and Safe Routes to School.			X	X
10. Maternal and Child Health provides an orientation session at the spring Public Health Conference for staff new to MCH to provide education and resources for developing / delivering MCH services for specific populations. Prevention of injury/death rel			X	X

b. Current Activities

Direct Services:

KTSRO/local communities continue CPS training/inspection/ provision of car seats providing education/resources for families. Of 108 CPS sites, 31 LHD are child safety seat inspection stations.

Enabling Services:

KDOT, SAFE KIDS/EMS-C coalitions provide information regarding CPS training opportunities for staff in local MCH programs.

Population-Based Services:

The Legislature approved a plan to update our drivers licensing system. Pending the Governor's approval, HB 2143 Graduated Drivers Licensing (GDL) proposal will make simple, but effective changes to current laws aligning Kansas with the 48 other states that have already passed similar measures for teen drivers. Key changes were made: A 12 month learner's permit period,

limitation of non-sibling passengers the first six months of full licensing, limiting late-night driving for six months, and prohibiting cell phone use while driving during the restriction period.

Infrastructure Building Services:

The MCH 2009 Orientation session provided an opportunity for new MCH staff to learn about issues related to child safety birth through age 18, as well as resources available to assist in educating families.

The Safe Routes to School program continues for schools that wish to participate.

The "Spot the Tot" program continues.

The ZIPS newsletter continues to be the vehicle for information/resources regarding prevention of unintentional injuries, including motor vehicle related injury / death.

c. Plan for the Coming Year
Direct Services:

SAFE KIDS will continue to work with community groups to distribute child safety seats and booster seats to low-income families, including CSHCN.

Enabling Services:

MCH staff will continue to inform, educate, and link families to resources for motor vehicle safety.

Population-Based Services:

SAFE KIDS and other child advocacy groups will actively support any proposed legislative changes to adopt a "primary" seat belt law for the state in 2010 which would allow law enforcement officers to pull over a motorist for violating Kansas law on seat belt use.

Infrastructure Building Services:

The 2010 MCH Orientation session will provide opportunities to inform new MCH staff about issues related to child safety birth through age 18.

LHD will target specific populations within their communities based on community needs assessments/concerns identified by the community to address unintentional injury/death involving MVC, pedestrian and other activities involving ATVs and bicycles.

Local MCH agencies will continue to be provided with information/resources for injury prevention programs within their agencies. Education and activities to reduce deaths related to motor vehicles will continue.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			25	23	24

Annual Indicator		37.8	42.3	42.1	42.1
Numerator					
Denominator					
Data Source					National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	45	45	45	45	45

Notes - 2008
The 2008 column is populated with 2007 data. Estimates for children born in 2006 will be available in August 2010.

Notes - 2007
Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services.

Final geographic-specific breastfeeding rates among children born in 2005, CDC's Breastfeeding National Immunization Data: Any by States: 2005.

http://www.cdc.gov/breastfeeding/data/NIS_data/2005/state_any.htm

Notes - 2006
Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services. Final geographic-specific breastfeeding rates among children born in 2004, CDC's Breastfeeding National Immunization Data: Any by States: 2004. http://www.cdc.gov/breastfeeding/data/NIS_data/2004/state_any.htm

a. Last Year's Accomplishments
In the 2007 provisional National Immunization Survey, 43.4% of Kansas children born in 2005 were breastfed at least 6 months, 2.6% higher than in 2006 (42.3%). This compares to 43.1% for the U.S. This estimate is getting closer to, but remains below the national Healthy People 2010 objective (50%). Over the six year period (2000-2005), there is a significantly increasing trend ($p<0.05$) in the percent of Kansas mothers who breastfed their infants at 6 months of age. The survey also shows that low income mothers are less likely to breastfeed than their higher income counterparts are.

According to the 2007 Pediatric Nutrition Surveillance System (PedNSS), which assesses breastfeeding status of children from low-income families (below 185% of poverty level) participating in WIC, 21.6% of WIC infants were breastfed at least 6 months, 2.7 % lower than in 2006 (22.2%). This was 15.0% lower than the percent for U.S. mothers (25.4%). This is well below the HP 2010 objective. Over the 8 year period (2000-2007), there is no statistically significant increasing or decreasing trend in the percent of WIC participant mothers who breastfed their infants at 6 months of age.

Enabling Services:

Continued the statewide breastfeeding public awareness campaign by maintaining breastfeeding support billboards in three prominent locations along the Kansas Turnpike and other busy Kansas highways.

Developed and distributed a series of "Breastfeeding Reminder Post Cards" and a Crib Card in coordination with the Breastfeeding Taskforce.

Worked with Medela to provide "Breast Pump 101" seminars in three locations in Kansas for LHD WIC staff and MCH staff.

Established the Kansas Breastfeeding Coalition. This coalition is made up of a wide variety of health care professionals and breastfeeding supporters across the state.

Maintained a lactation room that is available for all nursing women who are employed in the Curtis State Office Building.

Population-Based Services:

Provided all local agencies with a packet of ideas to help with the promotion of World Breastfeeding Week (WBW) activities in August 2008. Two agencies were awarded $200 worth of breastfeeding education and/or resource materials for outstanding promotion efforts.

Infrastructure Building Services:

Supported Breastfeeding Peer Counselor Programs in 19 Kansas counties. Peer counseling is a significant factor in improving breastfeeding initiation and duration rates among women in a variety of settings, including economically disadvantaged and WIC populations.

Supported Certified Breastfeeding Educator Training in April 2008.

State and local staff attended the USBC biennial conference in January 2008 and the NWA Nutrition and Breastfeeding Conference in September 2008. Provided twelve clinic staff with stipends to attend the NWA training in September.

Quarterly breastfeeding packets including a newsletter to share with other health professionals and new breastfeeding resources were distributed to 104 locations throughout the state.

Worked with the Governor's Child Health Advisory Board to develop breastfeeding workplace support policies and lactation room development guidelines. Completed policies and guidelines were forwarded to the Governor's Office for action.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support state agencies, LHD and private businesses to implement new or enhance existing breastfeeding friendly worksite policies.				X
2. Build and enhance relationships among community, public, non-profit and private sectors at the community, county and state level that support breastfeeding.		X		
3. Provide or support evidence-based continuing education on breastfeeding promotion and support.				X
4. Support breastfeeding credentialing efforts of LHD staff for both MCH and WIC programs.				X

5. Sustain a statewide public awareness campaign that supports breastfeeding.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Enabling Services:

Continue the statewide breastfeeding public awareness campaign with an emphasis on breastfeeding in the workplace.

Design and disseminate breastfeeding evaluation tools which are available to all local health departments and school nurses.

Work with the Kansas Breastfeeding Coalition (KBC) to enhance existing relations among public and private partners.

Support implementation of the KBC's Business Case for Breastfeeding Grant.

Increase access to breastfeeding resources.

Population-Based Services:

Coordinate a public awareness campaign for World Breastfeeding Week in August 2009. Provide all clinics who submit a summary of their activity with up to $75 worth of breastfeeding education and/or resource materials.

Infrastructure Building Services:

Build the capacity of leaders and members from all sectors of the community by supporting Certified Breastfeeding Educator Training in October 2008.

Promote quality training and/or credentialing of health professionals involved in breastfeeding promotion and support by providing information about upcoming educational opportunities, stipends to attend and underwriting speakers on breastfeeding topics for the statewide conferences.

Support evidenced-based breastfeeding related training of researchers and practitioners by distributing breastfeeding packets throughout the state. The packets will include a newsletter and breastfeeding resources which can be shared with other health professionals in their communities.

c. Plan for the Coming Year
Enabling Services:

Continue the statewide breastfeeding public awareness campaign with billboards.

Support existing Breastfeeding Peer Counselor Program.

Build and enhance relationships among community, public, non-profit and private sectors at the community, county and state level that support breastfeeding.

Population-Based Services:

Coordinate a public awareness campaign for World Breastfeeding Week (WBW) in August of 2010 by providing all local agencies with a packet of ideas to help with the promotion of WBW and provide participating agencies with breastfeeding education and/or resource materials.

Infrastructure Building Services:

Work with local health departments to improve staff competencies related to breastfeeding, including helping to sponsor Certified Breastfeeding Educator Training in at least one location.

Promote quality training and/or credentialing of health professionals involved in breastfeeding promotion and support by providing information about upcoming educational opportunities, stipends to cover registration and underwrite speakers on breastfeeding topics for the statewide conferences, including provision of the USDA's Loving Support Breastfeeding training to local clinic staff.

Support evidenced-based breastfeeding related training of researchers and practitioners by distributing breastfeeding packets throughout the state. The packets will include a newsletter and breastfeeding resources which can be shared with other health professionals in their communities.

Increase the number of settings where appropriate breastfeeding information can be accessed by health professionals, interested partners and breastfeeding families by supporting the development of a website for the Kansas Breastfeeding Coalition.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	98	98	98	98	98
Annual Indicator	96.2	87.9	95.3	96.4	97.4
Numerator	38925	35825	39951	41388	41485
Denominator	40449	40734	41910	42947	42584
Data Source					Kansas Newborn Screening program, 2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98	98	98	99	99

Notes - 2008

DATA SOURCE:
Numerator= KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2008 .
Denominator= KDHE. Office of Health Assessment. Kansas Live Birth by Occurrences.

Notes - 2007
Data Sources: Newborn Hearing Screening program 2007 (numerator); Vital Statistics occurrent births for 2007 (denominator).

Notes - 2006
Data Sources: Newborn Hearing Screening program 2006 (numerator); Vital Statistics occurrent births for 2006 (denominator).

a. Last Year's Accomplishments
Kansas has continued to screen at 95% or better since 2003. The percent of newborns screened before hospital discharge was 97.4% in 2008 an increase of .6% since 2007. Percentages for 2005 are reduced due to the implementation of a new web-based birth certificate system through the Office of Vital Statistics that did not allow for records from birth to be extracted for 15 months (through March 2006). This significantly impacted the program's ability to track infants needing additional testing in the first month of life.

Population Based Services:

The screening is implemented at the local level by hospitals, birthing centers or other obstetrical/newborn services licensed facilities. Sound Beginnings administered the statewide system for newborn Early Hearing Detection and Intervention (EHDI) including data management tracking and surveillance.

Enabling Services:

Collaboration and funding was provided for assistance with parent-to-parent support, and continual work to develop the parent-driven Kansas Hands & Voices Chapter family support organization. Audiology/EHDI Coordinator and Advisory member Parent representatives attended an EHDI Family Support National Meeting to assist with developing family support infrastructure and services for children and their families. Information resources to outpatient and diagnostic Audiology Providers were provided.

Infrastructure Building Services:

The Sound Beginnings Advisory Committee continued to meet quarterly and establish goals for each year to support the program and stakeholders.

English and Spanish newborn hearing screening informational brochures were provided to families at the hospital. Audiologists and Early Childhood Special Educators provided resource guides to families of infants and toddlers who have been identified with hearing loss.

Presentation provided by Carol Busch at the annual EHDI Conference with a focus on Family Awareness of communication choices/options. Otoacoustic Emission (OAE) training for Leavenworth and Olathe Parents as Teachers and to Infant Toddler Programs provided by Sound Beginnings staff.

Funding in the amount of $50,000 was approved from State general funds to implement a hearing aid loan bank.

Participated in Deaf Day at the Capital, State meetings working with stakeholders, Early Childhood Hearing Outreach State Team meeting, Kansas Commission for the Deaf and Hard of

Hearing Board Meetings and activities, Sound START Committee meetings, Deaf Blind Consortium meetings.

Audiology EHDI Coordinator provided hearing screens at state agency Health Fairs to educate consumers on screening equipment used with newborns.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue data submission through the web-based birth certificate (VRV) reporting system.			X	
2. Continue quarterly meetings of the Sound Beginnings Advisory Committee.				X
3. Continue the education training to professionals on early intervention.				X
4. Collaborate to assist Kansas Hands and Voices chapter enabling parental input and parent to parent support.		X		
5. Continue dissemination of Newborn Hearing Screening brochures for families to hospitals, etc.				X
6. Support to hospitals to enhance screening equipment.				X
7. Family and Audiologist Consultants to assist reduce loss to follow-up.				X
8. Formalization of a regional program to assist newly identified families at first contact.				X
9. Continued attendance at EHDI, parent support and deaf education focused meetings.				X
10.				

b. Current Activities
Population Based Services:

The screening is implemented at the local level by birthing facilities. Sound Beginnings administers the statewide system for EHDI including a data management tracking and surveillance system.

Enabling Services:

Continued collaboration and funding for Kansas Hands & Voices parent-driven family support organization.

Infrastructure Building Services:

Sound Beginnings will continue with Advisory Committee meetings and dissemination of brochures.

Continued submission of screening and diagnostic evaluation results through fax, mail and email. Follow-up is completed on missed, NICU, and failed screens by staff and by EHDI Coordinator for confirmed hearing loss to medical home providers, Part C local networks and families.

Site visits are made to hospitals and Audiologists upon request, due to limited staff of the program. Information and technical assistance is provided to all stakeholders on program via phone and email.

Support through grants to assist with reducing refer rate to include Automated Auditory Brainstem

Response equipment has been provided to Level III NICU Hospitals.

Continued work with support through grants is ongoing for reducing loss to follow-up and loss to documentation and tracking, surveillance and integration.

c. Plan for the Coming Year
Population Based Services:

The screening is implemented at the local level by birthing facilities including hospitals, birthing centers or other obstetrical/newborn services licensed facilities. Sound Beginnings administers the statewide system for Early Hearing Detection and Intervention including a data management tracking and surveillance system.

Enabling Services:

Continued assistance with the Kansas Hands and Voices Chapter family support organization group specifically for families of children who are deaf or hard of hearing to promote Parent-to-Parent program services to families, assist with a family support activities and assist parent consultants.

Infrastructure Building Services:

Continued submission of hearing screening results through the web-based birth certificate system and the Sound Beginnings database to accept the required Healthy People 2010 data fields including race, ethnicity, language spoken in the home, birth defects, and transferring hospital.

Support through CDC grant working towards developing a web-based module to allow Sound Beginnings to be integrated with the larger Kansas child-health system. A web-based system which is integrated with other state service divisions would help reduce the inefficiency and inaccuracies of the current system.

Collaborate with the Kansas School for the Deaf, Infant Toddler Services, University of Kansas Deaf Education program, Tiny-k networks, Hartley Family Center and the St. Joseph Institute for the Deaf to provide assistance and training for personnel at Tiny-k networks working with families of children identified with hearing loss and develop a regional program to assist in first contacts with families.

Continued technical assistance provided to hospital personnel, Audiologists, Early Interventionists, Medical Home and other stakeholders of newborn hearing screening and intervention services. Audiologist Consultants and Family Consultants will be contracted to assist local communities in reducing loss to follow-up and/or documentation.

Sound Beginnings' Newborn Hearing Screening Program Advisory Committee continues to meet quarterly. The committee has established goals for the Advisory year which begins in January that include the following: parent communication and family concerns; focus on education to all members involved in early intervention and focus on the family perspective; and, information sharing about legislative issues or advocacy from the Kansas Commission of the Deaf and Hard of Hearing or other organizations that are related to early hearing detection and intervention.

Support through mini grants will be provided to two hospitals that have a Level II or III NICU to purchase Automated Auditory Brainstem Response (AABR) equipment.

Staff, parents, and the Part C Coordinator continue to attend conferences focusing on Early Hearing Detection and Intervention (EHDI) issues, family support and Deaf Education including the National EHDI conference.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	5	5	6	6.5	7
Annual Indicator	6.3	6.2	7.3	7.7	7.7
Numerator					
Denominator					
Data Source					US Census. ASEC supplement. Table HI05
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	7	7	7	7	7

Notes - 2008
DATA SOURCE: U.S. Census Bureau and Burau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2007. Addition information can be found at http://www.census.gov/hhes/www/macro/032008/health/h05_000.htm

Data for 2008 is not available. 2007 data was used to pre-populate this performance measure.

Notes - 2007
DATA SOURCE: U.S. Census Bureau and Burau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2007. Addition information can be found at http://www.census.gov/hhes/www/macro/032008/health/h05_000.htm

Notes - 2006
Data Source: Table HIA-5. Health insurance coverage status and type of coverage by state -- children under 18: 1999 to 2006.
http://www.census.gov/hhes/www/hlthins/historic/hihistt5.html

a. Last Year's Accomplishments
The Kansas Association for the Medically Underserved (KAMU) reports Kansas is one of 10 states where the percentage of people without health insurance increased in the most recent reporting period. In 2005, services were provided to 119,921 patients (329,182 visits). In 2007, the most recent year for which data is available, services were provided to 169,535 unduplicated users (480,367 visits) - an increase of 41% in two years.

The recession has created challenges for insuring children and families. According to the March 2007 Current Population Survey (CPS) 7% of Kansas's children under age 19 were not covered by any insurance at any time during the year. The February 2008 KHI report, "Health Insurance and the Uninsured in Kansas", finds almost half (47 percent) of the uninsured in Kansas are young adults age 19-34, a vulnerable population of childbearing age.

HealthWave, the State Children's Health Insurance Program (SCHIP) that includes Medicaid is directed by the Kansas Health Policy Authority (KHPA). Two managed care groups are responsible for administering Medicaid/HealthWave: Children's Mercy Family Partners and Unicare. According to a February 2009 report from the Kansas Legislative Research Department and KHI, "Kansas Medicaid: A Primer", the average monthly enrollment for children age 19 and under during 2008 is 153,467 enrolled in HealthWave 19 (Medicaid) and 37,864 enrolled in HealthWave 21 (SCHIP).

State budget cuts forced agencies to reduce budgets, including KHPA, with reductions in staffing in critical areas of Medicaid operations. In May of 2009, the State Medicaid director reported a backlog of unprocessed applications that has been growing for several months and without additional resources, the number of people whose applications have been pending 30 days or longer could grow to 50,000 by December 2009.

After a grueling debate over balancing the State budget with cuts and revenue enhancements, funding for HealthWave 21 or SCHIP expansion was included in the budget for Fiscal Year 2010 for $1.2 million from the Children's Initiative Fund to expand eligibility for SCHIP from 200 to 250 percent of the 2008 federal poverty guidelines. The expansion is expected to serve an additional 9,000 uninsured children. Children who are not citizens of the U.S. or who cannot provide primary documentation are not eligible for these programs. The identification requirements through the federal Deficit Reduction Act of 2005 resulted in 18,000-20,000 Kansas beneficiaries losing coverage during 2006-2008.

The Uninsured: A Closer Look (2009) showed that Kansans of racial and ethnic minorities are disproportionately represented among the uninsured. Fifty five percent of Hispanics / Latinos, 37.9 percent of African Americans, and 39.6 percent of "other" ethnic minorities were uninsured. This compares with 27.7 percent for whites. However, most uninsured Kansans are non-Hispanic whites (69.7 percent).

Direct Services:

Primary care safety net clinic funding/number of clinics expanded care for all patients without a medical home regardless of their ability to pay. Some clinics provide a true medical home through integrated medical, dental and behavioral health services.

Enabling Services:

The Legislature approved expansion for health care services for pregnant women and children extending HealthWave eligibility limits from 200 to 250 percent of poverty. No funding was allocated for the expansion.

Population-Based Services:

MCH educated partners and families of children about the availability Medicaid/HealthWave and their eligibility. Healthy Start Home Visitors (HSHV) provided HealthWave outreach to families in several settings, including childcare.

Infrastructure Building Services:

The 2008 Legislature appropriated $700,000 to increase safety net clinic capacity and appropriated $500,000 for the dental hub program in 2008. Total funding for of the dental hub project was $2.8 million with commitments from foundations.

Kansas was one of eight states selected for advancement of the Medical Home concept by the National Academy for State Health Policy Medical Home Project (NASHP) in partnership with

Patient-Centered Primary Care Collaborative (PCPCC). KPHA leads this initiative/is positioned to request American Recovery and Reinvestment Act (ARRA) funding for further development of electronic health information exchange and telemedicine through Health Information Technology (HIT) / Health Information Exchange (HI

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assist families with Medicaid/HealthWave application and the establishment of a medical home.		X		X
2. Local health departments develop outcome-based plans to decrease the percent of children without health insurance in their regions.				X
3. Link the integration of the Medicaid/HealthWave Program applications for families attending child care/school, accessing community resources basic services, or in health/dental clinics.		X	X	X
4. Link families with Medicaid/HealthWave by assisting with the enrollment application.		X		
5. Promote outreach activities in local education agencies by school nurses, school social workers, and school psychologists to enroll Medicaid eligible women and children.			X	X
6. Healthy Start Home Visitors assist families to enroll in Medicaid/HealthWave Programs.		X	X	
7. Link students with Medicaid/HealthWave coverage through school health services.		X	X	
8. Promote local coordination and collaboration between agencies to link hard-to-reach and disparate populations to Medicaid/HealthWave Programs.			X	X
9. Assist local health agencies to create a community plan for linking families to safety net clinics/dental hubs and in providing care for those uninsured children who remain ineligible for Medicaid / HealthWave Programs.	X	X	X	X
10.				

b. Current Activities

Direct Services:

Thirty six primary care safety net clinics provide a medical home for patients. Over 90 percent of patients seen in safety net clinics have incomes less than 200 percent of poverty. There are 18 clinics receiving dental hub funding from the State and/or private foundations.

The Kansas Statewide Farmworker Health Program has 128 access points.

Enabling Services:

Beginning July 1, 2009, the Health Care Package will extend HealthWave eligibility limits from 200 to 250 percent of poverty resulting in about 4,600 additional children receiving health coverage in 2010 and as many as 9,000 additional children by 2012.

Population-Based Services:

MCH continues collaboration with private/public providers and service agencies/organizations to educate families about Medicaid/HealthWave programs, assisting families with enrollment as needed.

Infrastructure Building Services:

Kansas has accepted ARRA funding. According to www.recovery.gov, of the $993 million dollars received, $71,575,227 will be designated to the Medical Assistance Program.

Kansas AAP and KHPA continue to work together to improve capacity/standards for EPSDT. Social-emotional screening and training is emphasized.

Child care health consultation training (CCHC) was completed May 2009 with 13 registered nurses and included assuring medical homes for children in child care. The KU School of Education is evaluating the utilization/outcomes of the training.

c. Plan for the Coming Year
Direct Services:

MCH will continue to promote access to primary care clinics and private providers to establish medical homes. These sites will assist families to enroll in HealthWave programs and link to care.

Enabling Services:

The MCH program will continue to assist local MCH staff in locating resources for uninsured women and children. This involves very close cooperation with the Center for Health Disparities, Refugee Health, Migrant and Farmworker Health programs and others.

Population Based Services:

MCH staff will continue to support and promote outreach activities in local health and education agencies to enroll Medicaid eligible women and children and to encourage their use of health services available to them.

Infrastructure Building Services:

Kansas will develop a plan for federal funding through ARRA to improve health outcomes by promoting a medical home model of care following ARRA federal funding guidelines not published as of May 2009. Efforts to merge HIT / HIE into a comprehensive plan will provide a "shovel ready" project for applying for funding through the Health Information Technology for Economic and Clinical Health Act (HITECH).

The MCH Program will assist KHPA to enroll all eligible children in child health insurance programs, monitor progress in enrollment and to determine strategies to be incorporated into the education of providers enrolling families in public insurance programs.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			30	30	29
Annual Indicator		30.3	30.8	30.1	30.1
Numerator		10114	6900	9474	9474

Denominator		33378	22404	31476	31476
Data Source					Pediatric Nutriton Surveillance System, 2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	29	28	28	28	28

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Fall 2009.

Notes - 2007
Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2007 (Kansas WIC database).

Notes - 2006
The numbers presented for 2006 do not represent all the WIC participants due to a new data base roll-out.

a. Last Year's Accomplishments
According to the 2007 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families (below 185% of poverty level) participating in WIC, 30.1% of low-income children ages 24-59 months in Kansas were at risk of overweight or overweight. Kansas data is not significantly different from that for the U.S. (31.3%). The percentage of WIC participants at risk of overweight or overweight decreased 2.3% from 2006. However, the change was not statistically significant. Over the 8 year period (2000-2007), there is a statistically significant increasing trend ($p<0.05$) in the percent of WIC participants at risk of overweight or overweight.

Enabling Services:

Worked with the Office of Health Promotion to promote a statewide event focused on increasing physical activity among 3rd grade students. The event was held May 2, 2008 with approximately 17,600 participants at 40 sites located throughout the state.

Worked with the Governor's Food Security Task Force to develop and provide LHDs with a guide to Kansas Food Resources to assure access to healthy food choices.

Population-Based Services:

School nurses were surveyed to assess if school aged children are being weighed, measured and referred, as appropriate. Data were inconclusive and data gathering methods will be changed for next year's survey. The importance of assessing height, weight and BMI's of school aged children was covered in newsletters and trainings targeting school nurses.

Infrastructure Building Services:

As a part of the action plan developed by the Kansas USDA nutrition programs, three communities held community wide events to increase healthy eating behaviors. Incentives to

increase physical activity and encourage healthy eating behaviors were provided to event participants.

Worked with the Coordinated School Health program, Blue Cross and Blue Shield Foundation of Kansas, Healthy Kids Kansas and Community Health Assessment to assist communities, child care facilities and schools in obtaining grants for communities to address healthy eating and physical activity.

LHDs were encouraged to attend the October 2007 Built Environment summit.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assure access to a food supply and healthy food choices.			X	
2. Assure access to safe, affordable opportunities to be physical active.			X	
3. Identify funding resources and partners.		X	X	
4. Utilize and improve data systems.		X	X	X
5. Use and communicate results of program and policy interventions that contribute to evidence-based strategies.		X		X
6. Increase the number of well-trained MCH personnel who support healthy eating and physical activity.				X
7. Promote consistent messages with best evidence available.		X	X	
8.				
9.				
10.				

b. Current Activities
Enabling Services:

Continue working with the Office of Health Promotion to promote the Kansas Kids Fitness Day, a statewide event focused on increasing physical activity among 3rd grade students in Kansas.

Develop and disseminate a list of training websites and resources that promote good nutrition and physical activity for use by LHD staff.

Infrastructure Building Services:

Facilitate MCH staff in obtaining continuing education to promote, deliver and evaluate services to support healthy eating/physical activity by encouraging attendance at the Symposium on Adolescent Health Issues.

State staff will attend CDC's Weight of the Nation Conference and the Annual Meeting of the Association of State and Territorial Public Health Nutrition Directors for training on evidence-based research approaches, methods and policy development.

Provide training on community-based participatory research approaches by encouraging LHD staff to attend the 2008 Built Environment Summit.

Work with the Coordinated School Health program, Blue Cross and Blue Shield Foundation of Kansas, Healthy Kids Kansas and Community Health Assessment to assist communities, child care facilities and schools in obtaining grants for communities to address healthy eating and

physical activity.

Population-Based Services:

Survey school nurses to assess if school aged children are being weighed, measured and referred, as appropriate.

Promote increased intake of fruits and vegetables by implementing the new WIC food package

c. Plan for the Coming Year
Enabling Services:

Model health education and physical activity for 3rd grade students in Kansas, by working with the Office of Health Promotion to promote the Kansas Kids Fitness Day, a statewide event focused on increasing physical activity among 3rd grade students in Kansas. Nearly half of all third graders in the state of Kansas participate each year.

Promote the use of existing online staff educational programs that promote good nutrition and physical activity.

Population-Based Services:

Survey school nurses to assess if school aged children are being weighed, measured and referred, as appropriate. Importance of assessing these parameters will be covered in newsletters and trainings.

Work with the Office of Health Promotion and other stakeholders to design and promote consistent and culturally appropriate nutrition and physical activity messages.

Infrastructure Building Services:

Assist LHDs in identifying and accessing funding streams that could potentially support nutrition and physical activity programs at the community level.

Strengthen processes and mechanisms to assist LHDs in successful grant writing by identifying online training resources and workshops or through support of speakers at public health conferences.

Enhance the socioeconomic development, organization and project management, policy research, and meeting facilitation and data collection and evaluation in state and local programs.

Increase the number of well-trained MCH staff who plan, facilitate, deliver and evaluate healthy eating and physical activity messages. Use and communicate to LHDs the education gained from CDC's Weight of the Nation Conference, the Annual Meeting of the Association of State and Territorial Public Health Nutrition Directors, and other national meetings.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Performance Objective			12.3	13.5	13.5
Annual Indicator		14.0	14.2	13.7	13.7
Numerator		5577	5814	5729	5729
Denominator		39701	40896	41951	41951
Data Source					Kansas Vital Statistics, 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	13	13	12.5	12.5	12.5

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Fall 2009.

Notes - 2007
Data Source: Birth certificate (resident) data, 2007, Center for Health & Environmental Statistics, KDHE

Data prior to 2005 are not comparable due to the revision of the Kansas Birth Certificate.

Notes - 2006
2005 data is not comparable to data from previous years since it is collected from the revised birth certificate.

a. Last Year's Accomplishments
Cigarette smoking during pregnancy adversely affects the health of both mother and child. It increases the risk for adverse maternal conditions and poor pregnancy outcomes. Infants born to mothers who smoke weigh less than other infants, and low birth weight (<2,500 grams) is linked with infant mortality and other adverse health outcomes for mother and child. In 2007, 13.7% (5729) of women reported smoking during the last three months of pregnancy, a 3.5% decrease from 2006. This decrease was statistically significant ($p<0.05$). Over the three year period (2005-2007), there was no significantly increasing or decreasing trend detected. Among women who reported smoking during the last three months of pregnancy, 50.7% reported Medicaid as primary source of payment for the delivery.

Direct Services:

Tobacco cessation assistance was provided to pregnant women referred to the Kansas Tobacco Quitline (Quitline) and to local tobacco cessation clinical provider services.

Enabling Services:

MCH grantee prenatal care coordinators throughout the state provided screening, counseling and referral to tobacco cessation services available in their local communities.

Infrastructure Building Services:

In collaboration with the MCH Program at KDHE, the Kansas Tobacco Use Prevention Program (TUPP) encouraged local agencies to use the Quitline and other smoking cessation

aids/materials. These local agencies affect about 70% of Kansans. Also, local prenatal care providers were encouraged to participate in the National Partnership to Help Pregnant Smokers Quit telephone conferences for updates.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH encourages LHD staff and local perinatal healthcare providers to attend tobacco cessation trainings when available to help decrease the number of pregnant women that smoke tobacco.			X	X
2. MCH encourages LHD staff and local perinatal healthcare providers to refer pregnant women to Quitline and local tobacco cessation services to help decrease the number of pregnant women that smoke tobacco.	X		X	X
3. MCH and the Kansas TUPP coordinate referrals with LHD programs and local perinatal healthcare providers to provide a linkage for pregnant women to tobacco cessation services.		X		X
4. LHD and local perinatal healthcare staff trained in the use of the 5 A's counseling approach to smoking cessation provide brief interventions to assist pregnant women to quit smoking tobacco.	X			
5. MCH staff link LHD and local perinatal healthcare staff to and encourage their participation in the National Partnership To Help Pregnant Smokers Quit telephone conference for updates in practice methodologies.		X		X
6. MCH staff provides LHD and local perinatal healthcare staff with relevant tobacco cessation resources via the Web, educational conferences, newsletter articles and other routine communications.		X		X
7. MCH staff educates LHD and local perinatal healthcare staff to assess pregnant women for smoking behaviors and tobacco use and provides information on the risks associated with continued smoking and provides/refers to local smoking/tobacco cessation.		X		
8. MCH staff in collaboration with the Kansas TUPP and partnering tobacco-free coalitions will continue to monitor local and state-wide smoking/tobacco cessation ordinances/legislation.				X
9.				
10.				

b. Current Activities

Direct Services:

Pregnant women are provided tobacco cessation assistance by referrals to the Quitline, local healthcare provider tobacco cessation programs, local activities through community coalitions and youth organizations.

Enabling Services:

Prenatal providers and MCH local agencies are given relevant tobacco cessation information/resources through newsletter articles, involvement with the Kansas TUPP and routine communications with MCH staff. Referrals to the Quitline and local cessation services are provided and local agency staff is encouraged to screen, educate and refer pregnant women to

appropriate resources.

Infrastructure Building Services:

continued evaluation of birth outcomes and smoking rates compared with local agency efforts in prenatal smoking prevention and cessation.

Kansas TUPP and MCH staff encourages local agencies to use the Quitline and other materials that aid people to quit smoking.

MCH grantees and other prenatal providers are encouraged to participate in the National Partnership to Help Pregnant Smokers Quit telephone conferences.

The Kansas TUPP disseminates an annual report to interested stakeholders that evaluates the efforts of participating organizations implementing the 5 A's approach and many other tobacco-related issues.

The Kansas TUPP reported smoke-free ordinances in 35 cities in Kansas. Also, there were 3 county smoke-free resolutions in Johnson, Pratt and Harvey Counties covering unincorporated areas.

c. Plan for the Coming Year
Direct Services:

Tobacco cessation assistance will continue to be provided to pregnant women utilizing the 5A's tobacco use prevention method through local tobacco cessation clinical provider services with additional support from the Kansas Tobacco Quitline.

Enabling Services:

In collaboration with the Kansas TUPP, MCH grantee agencies and local prenatal care providers will provide screening, counseling and referral services for pregnant women and women of reproductive age. The Quitline, local tobacco cessation services and activities of local community coalitions will assure education and support to help women quit using tobacco.

MCH staff will continue to provide relevant tobacco cessation information/resources through newsletter articles and in routine communications to local agencies and local healthcare providers.

Kansas home visitation staff will continue outreach services to pregnant women and their families providing smoking cessation resources and referrals.

Currently Medicaid does not pay for tobacco cessation counseling. Medicaid does pay for the Zyban and Chantix patch but does not pay for the gum, spray, inhaler, or lozenge. MCH staff will continue to encourage Medicaid reimbursement for tobacco cessation counseling.

MCH staff will further develop relationships with partnering organizations, stakeholders, programs and agencies to maintain and develop tobacco cessation resources for pregnant and preconceptional women.

Population-Based Services:

MCH staff will encourage grantees and partners to pursue available tobacco cessation training and refer pregnant women to the Quitline and other local tobacco cessation resources for follow-up support services.

Infrastructure Building Services:

Some capacity is in place to provide tobacco cessation counseling and referral by prenatal service providers in the state. MCH staff will provide technical assistance to local grantee agencies regarding billing for tobacco cessation counseling in an effort to support sustainability and encourage local programs to participate in the National Partnership to Help Pregnant Smokers Quit telephone conferences for updates.

MCH staff will monitor data on tobacco cessation sent in by local MCH grantees serving pregnant women.

MCH staff in collaboration with the Kansas TUPP and partnering tobacco-free coalitions will continue to monitor local and state-wide smoking/tobacco cessation ordinances/legislation.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	6.5	6.3	8	7.5	9.4
Annual Indicator	8.3	7.9	9.5	10.1	10.1
Numerator	51	48	58	61	61
Denominator	614974	610153	607746	606239	606239
Data Source					Kansas Vital Statistics, 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	9.3	9.2	9.1	9	9

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Fall 2009.

Notes - 2007
Data Source:
Numerator = Death certificate (resident) data, 2007, Center for Health & Environmental Statistics, KDHE

(2007 data=2005-2007).
Reporting years were combined to calculate 3 year rolling averages due to small sample size.
ICD-10 coding: X60-X84,Y870.

Denominator = U.S. Census estimates (Bridged-Race Vintage data set), 2007

Notes - 2006
Data Source:
Numerator = Death certificate (resident) data, 2006, Center for Health & Environmental Statistics, KDHE

(2006 data=2004-2006).
Reporting years were combined to calculate 3 year rolling averages due to small sample size.
ICD-10 coding: X60-X84,Y870.

Denominator = U.S. Census estimates (Bridged-Race Vintage data set), 2006

a. Last Year's Accomplishments
In 2007, the suicide rate among Kansas youth ages 15-19 was 10.9 per 100,000. This was 8.0% lower than 2006 (11.9 per 100,000). For 2004-2006, the suicide rate for Kansas youth (9.5) was 23.5% higher than the U.S. rate (7.7). For the period 1997-2007, using rolling 3 year averages, there is a statistically significant decreasing trend ($p<0.05$) in completed suicides by Kansas youth (15-19). However, the 2005-2007 rolling average was 5.5% higher than that for 2004-2006. Completed suicides in 2007 were in geographically diverse areas of the State.

In 2006, youth suicide is the second cause of death in Kansas 15-24 year olds. For the U.S. (the most recent year national data for this age group is available) is the third cause of death for this age group.

According to the 2005 Kansas Youth Risk Behavior Survey (YRBS), 13.0% of Kansas high school students had seriously considered attempting suicide during the past 12 months. This rose to 13.9% in 2007, about 1 out of every 7 students. The percentage of students who made a plan about how they would attempt suicide during the past 12 months was 9.6% in 2005 and again in 2007 (1 of 10). Of students surveyed in 2005 and again in 2007, 6.5% and 6.7% respectively of the students who were surveyed actually attempted suicide one or more times during the past 12 months. The percent of students that attempted suicide and had to be treated by a doctor or nurse during the past 12 months was 1.6% in 2005 and 2.1% in 2007. Youth who attempt suicide have associated mental health or other behavioral concerns such as depression, substance abuse, and a sense of hopelessness, increased stress and a lack of family support.

Direct Services:

School counselors, school psychologists, and mental health professionals continued to provide limited individual and family therapy counseling through the local mental health consortium agreements, some of which used telemedicine technology.

Enabling Services:

The mental health consortiums continued to provide education through conference presentations to train professionals working with youth in mental health best practice protocols.

Population-Based Services:

Social and Rehabilitative Services (SRS) and National Alliance on Mental Illness (NAMI) offered an annual conference. Consumers, family members and providers receive support and training in best practices.

Trego County provided extensive Yellow Ribbon prevention training to stop an apparent suicide epidemic among adolescents.

Infrastructure Building Services:

KS applied for but did not receive the SAMHSA, Garrett Lee Smith grant funding.

The Suicide Prevention Subcommittee (SPS), an entity of the Governors Mental Health Services Planning Council worked on a state-wide suicide prevention plan that is now posted on the SAMHSA Suicide Prevention Resource Center web site. The plan promotes the the development and use of evidenced-based suicide prevention interventions, tailored to high-risk groups, designed with cultural and age-group competence, and structured for consistent and effective delivery.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participate in the Governor's Mental Health Services Planning Council and SPS to implement the state wide suicide prevention strategic plan.		X	X	X
2. SPS will develop culturally appropriate, effective suicide prevention strategies for specific populations in the State.				X
3. Develop infrastructure of mental health/suicide specialist so referral sources will be available when screening programs are implemented.		X		X
4. Assist making linkages from Kansas schools to KU telemedicine programs for counseling and mental health services to decrease suicide ideology.		X		X
5. Ask school nurses that are implementing a suicide prevention program in their schools for feedback through a school nurse survey to evaluate program implementation.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Direct Services:

Kansas schools continue to connect to the Telemedicine network, their local mental health centers, and KU to provide limited mental health services to rural areas of KS.

Enabling Services:

Kansas University developed a Community Tool Box with models of community change based on internal and external assets that contribute to the healthy development of adolescents. The toolbox defines the problem of suicide, establishes goals and implements a community focused solution.

MCH grantees are encouraged to use Bright Futures tools to improve suicide screening interventions.

Technical assistance is available to Kansas School Nurses to develop Yellow Ribbon Suicide Prevention Programs in their communities.

Population-Based Services:

'Caring for the Caregiver and the Implications of Compassion Fatigue' was presented to 404 school nurses at the annual statewide summer conference for Kansas School Nurses.

KU provided programs in stress management and mental health concerns to school nurses using telemedicine broadcast technology.

Infrastructure Building Services:

TSupported the SPS proposal to require suicide prevention training CEUs by the Behavioral Sciences Regulatory Board for relicensure and creating certification for professionals specialized in suicide prevention.

Assess school nurses for suicide prevention plans.

The Assure Better Child Development Plus (ABCD+) group formed to improve mental health screening, referral and resources.

c. Plan for the Coming Year
Direct Services:

Limited direct mental health services for school children will be continued through KU telemedicine and local mental health providers. Expansion of services will be explored using endowment funds KU received for this project.

Enabling Services:

Adolescent health staff will explore ways to integrate suicide prevention information and strategies into MCH, school health, and other community programs.

The Community Toolbox and Bright Futures will be encouraged and supported for suicide prevention with articles in newsletters, trainings and conferences.

Population-Based Services:

School nurses will be encouraged to initiate Yellow Ribbon Suicide Prevention Programs in their schools and technical assistance will be available to develop a school suicide prevention plan.

The annual school nurse survey will be used to measure the number of schools that have a suicide prevention plan in place.

KDHE will support efforts through consortia to reduce access to lethal means and methods of self harm.

Infrastructure Building Services:

The ABCD+ committee is developing an internet-based referral resource directory of mental health providers in Kansas that provide services to children. Plans are to instruct medical providers in Kansas on the use of screening tools, reimbursement codes, and provide information on the resource directory.

MCH will continue to promote the goals & strategies of the KS Suicide Prevention plan.

The SPS will continue to work to secure sustainable funding for the suicide prevention efforts in

KS.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	86	84	84	85	85
Annual Indicator	80.4	83.1	79.5	82.8	82.8
Numerator	385	402	380	434	434
Denominator	479	484	478	524	524
Data Source					Kansas Vital Statistics, 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	86	86	87	87	87

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Fall 2009.

Notes - 2007
Data Source: Birth certificate (resident instate births) data, 2007, Center for Health & Environmental Statistics, KDHE

Kansas's level III hospitals are HCA Wesley Medical Center (Wichita), Via Christi-St. Joseph, (Wichita), Stormont-Vail Regional Medical Center (Topeka), HCA Overland Park Medical Center (Overland Park), Shawnee Mission Medical Center (Merrian) and Kansas Bell Memorial Hospital (Kansas City).

Notes - 2006
Data Source: Birth certificate (resident instate births) data, 2006, Center for Health & Environmental Statistics, KDHE

Kansas's level III hospitals are HCA Wesley Medical Center (Wichita), Via Christi-St. Joseph, (Wichita), Stormont-Vail Regional Medical Center (Topeka), HCA Overland Park Medical Center (Overland Park), Shawnee Mission Medical Center (Merrian) and Kansas Bell Memorial Hospital (Kansas City).

a. Last Year's Accomplishments
In 2007, the percent of very low birth weight infants delivered in subspecialty perinatal care facilities was 82.8%, a 4.2% increase from 2006 (79.5%). This increase was not statistically significant. Over the ten year period (1998-2007), there is a significantly increasing trend ($p<0.05$) in the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates.

Direct Services:

Services were provided in subspecialty perinatal care facilities in the Wichita, Topeka and Kansas City metropolitan areas.

Enabling Services:

Obstetrical providers in the public and private sectors utilized a variety of methods to identify women at risk for preterm delivery or other complications that potentially lead to the delivery of very low birthweight infants.

Population-Based Services:

MCH grantee staff provided pregnant women with the warning signs of premature labor along with instructions about what to do if they experience any of the signs of early labor.

Infrastructure Building Services:

Due to modifications in the data system at the Kansas Department of Health and Environment (KDHE), the Perinatal Casualty Report (a set of perinatal outcome data), prepared by KDHE was not available for distribution. MCH staff monitored residence and occurrence data relating to delivery site for very low birth weight infants.

Kansas maintained a provider-driven perinatal referral system that facilitates access to inter-city/county/region consultation between primary obstetrical care providers and specialty maternal-fetal medicine professionals. This system included six hospitals that self-designate as subspecialty perinatal care centers providing out-patient and in-patient high risk obstetrical/fetal and neonatal services: Wesley Medical Center and Via Christi-St. Joseph Campus, Wichita; Stormont-Vail Health Care Center, Topeka; and Overland Park Regional Medical Center, Shawnee Mission Medical Center and the University of Kansas Medical Center in the Kansas City area. Three of the subspecialty perinatal care centers continued to provide formalized perinatal transport systems to maximize the potential for the delivery of referred high-risk obstetrical cases from outlying communities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide workforce educational opportunities in partnership with PAK, KHA, hospitals and other health care providers and a plan to develop and disseminate website and educational materials.		X		X
2. Hold meetings to discuss implementation of an electronic format for providing hospitals perinatal outcome data used for evaluation of high-risk obstetrical case management.				X
3. Develop protocols for obstetrical case management of maternal transfer and improvement of pre-/interconception health with PAK, hospitals and KHA.		X	X	X
4. Develop map of perinatal care system.				X
5. Provide information to health care providers concerning levels of perinatal health care services available in obstetric care facilities.				X
6.				
7.				
8.				

9.				
10.				

b. Current Activities
Direct Services:

Services are provided in subspecialty perinatal care facilities in metropolitan Wichita, Topeka and Kansas City.

Enabling Services:

Local obstetrical providers utilize many methods to identify women at high risk for preterm delivery or complications that will potentially lead to the delivery of very low birth weight infants.

Infrastructure Building Services:

The Perinatal Association Kansas (PAK), March of Dimes and MCH provides a forum for dialogue about state perinatal health issues and provides educational opportunities to MCH grantees, private providers and hospitals on current best practices.

The Kansas Perinatal Council (KPC) continues to pursue the objective of obtaining a Birth Spacing (i.e., Fmaily Planning) Waiver for Kansas and is developing a substance abuse protocol for pregnant women with the Kansas Child and Adolescent Health Council. Further, both councils are working with the Kansas Breastfeeding Coalition (KBC) to increase breastfeeding initiation and duration rates.

The Kansas Hospital Association (KHA) stated that they could only commit to participate with the KPC on issues of mutual interest as part of a subcommittee or similar arrangement.

Meetings are being planned to discuss the feasibility of providing perinatal outcome information to hospitals using an electronic format and current information will be available to hospitals.

c. Plan for the Coming Year
Direct Services:

Services will continue to be provided in subspecialty perinatal care facilities in metropolitan Wichita, Topeka and Kansas City.

Enabling Services:

MCH program staff will continue all of the items listed in Current Activities section.

Population-Based Services:

MCH will develop website resources and disseminate educational materials to providers of care to pregnant women, information to recognize the signs of preterm labor, and other high-risk obstetrical conditions with instructions to seek immediate obstetrical care.

MCH will assist PAK to make a concerted effort to provide professional education and consultation to obstetrical delivery facilities and advocate for delivery of very low birthweight infants in subspecialty perinatal care facilities.

Infrastructure Building Services:

MCH staff will continue all of the items listed in the Current Activities section.

MCH will pursue increasing active participation from the KHA when discussing plans to enhance perinatal health outcomes through increased hospital education and policy development.

MCH will provide health care providers information on the level of perinatal care services each obstetric facility provides on an as-needed basis. Kansas obstetric facilities self-designate the level of perinatal care services provided.

MCH staff will ontinue work on developing a map of the Kansas perinatal health system.

MCH plans to provide a more in-depth analysis of the statistics related to VLBW infants in terms of delivering hospital, maternal and infant transport, the effects of race and ethnicity, access to health care and infant outcomes to help guide policy development in this area.

Due to budget considerations and repeated overlapping issues, the Bureau of Family Health at KDHE will to combine the KPC and KCAHC into a single multi-disciplinary group of professionals with expertise in MCH that provides guidance and a shared mission on MCH best practice health issues.

Make perinatal outcome data available to hospitals more efficiently using an electronic format.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	88	88	89	78	78
Annual Indicator	85.9	76.0	75.0	72.4	72.4
Numerator	33967	27687	28286	28677	28677
Denominator	39553	36430	37733	39597	39597
Data Source					Kansas Vital Statistics, 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	79	79	80	80	80

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Fall 2009.

Notes - 2007
Data Source: Birth certificate (resident) data, 2007, Center for Health & Environmental Statistics, KDHE

Data prior to 2005 are not comparable due to the revision of the Kansas Birth Certificate.

Notes - 2006
Data Source: Birth certificate (resident) data, 2006, Center for Health & Environmental Statistics, KDHE

Data prior to 2005 are not comparable due to the revision of the Kansas Birth Certificate.

a. Last Year's Accomplishments
In 2007, 72.4% of infants were born to pregnant women receiving prenatal care in the first trimester, a 3.5% decrease from 2006 (75.0%). This decrease was statistically significant ($p<0.05$). The U.S. data for 2006 on this performance measure was 69.0%. Kansas exceeded the U.S. on this measure by 3.4% in 2006. Over the three year period (2005-2007), there was a decreasing trend detected, but not statistically significant.

Direct Services:

In 2007, 87 MCH grants were awarded covering 101 counties and served 10,042 mothers and infants who received prenatal care/care coordination, postpartum and infant health services. Eight agencies continued to provide medical prenatal care due to lack of available providers in their communities.

Enabling Services:

In 2007, Healthy Start Home Visitors (HSHV) provided education, support and referrals to community services for 9,043 women during outreach visits. Educational materials including an emergency management backpack provided through a grant through St. Louis University as well as fire prevention resources were provided. The HSHV encouraged use of the toll-free, Make a Difference Network (MADIN) number that provides pregnant women information about community resources.

Funding continued from the Kansas Medicaid program for providers in high-risk communities for "Healthy Babies Initiatives" that provide extra case management and care coordination for pregnant women enrolled in Medicaid. MCH staff continued collaboration with the Farm Worker Health Program to help assure outreach and access to prenatal care services for a mostly Hispanic migrant population, many with primary language of Low German or Spanish.

Population-Based Services:

Continue to identify women at risk for late entry and/or no prenatal care in coordination with the Supplemental Nutrition Program for Women Infants & Children (WIC), MCH, and Family Planning programs. MCH program staff continued an educational partnership with the March of Dimes (MOD) to disseminate information on perinatal health care topics with a focus on the importance of early prenatal care and prevention of premature delivery.

Infrastructure Building Services:

Due to modifications in the data system at the Kansas Department of Health and Environment (KDHE), the Perinatal Casualty Report (a set of perinatal outcome data), prepared by KDHE was not available for distribution.
MCH staff provided technical assistance to MCH grantees in developing and continuing translation services and print materials primarily in Spanish for the increasing Hispanic population in Kansas to encourage them to seek early prenatal care. MCH program staff continued collaboration with the MOD, the Juvenile Justice Authority, Pregnancy Maintenance Initiative projects, Federally Qualified Health Centers and Comprehensive School Health Centers to encourage early and regular prenatal care for all pregnant women. Workforce development and training were provided during the third annual Governor's Conference on Public Health.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide Prenatal Care/Care Coordination Services.	X		X	
2. Identify women at risk for late entry or no prenatal care.		X	X	
3. Partner with MOD Prematurity Campaign by educating on signs of premature labor.				X
4. Development of prenatal, delivery and postnatal provider databases.		X		X
5. Provide toll-free MADIN line.		X		
6. Encourage greater use of readily available data systems (e.g., KIC, Vital Stats, etc.,).				X
7. Promote early and comprehensive prenatal health care through all available means.		X	X	X
8. Promote optimal health during the interconception period.			X	X
9. Support/encourage local efforts to overcome disparities in the provision of prenatal care and incidence of low birth weight.		X		
10.				

b. Current Activities

Direct Services:

Care coordination and case management are used by local lMCH agencies to provide prenatal services. Maintain the number of clinics providing this type of service delivery in 2009.

Enabling Services:

MCH staff supports local education and outreach strategies by providing resources to improve access for pregnant women to comprehensive prenatal care services. Wyandotte County collaborates in a system of prenatal care services with area hospitals, obstetrical providers serving new parents. The Healthy Babies program in Sedgwick County uses an intense nurse case management approach to provide high-risk families information and support.

Population-Based Services:

Prenatal outreach is provided through coordination with Family Planning, WIC and MCH. These programs offer assistance in navigating the healthcare system and help clients complete the necessary paperwork.

Infrastructure Building Services:

MCH collaborates with the Perinatal Association of Kansas (PAK), the Kansas Health Policy Authority, the MOD and others in identifying/promoting best practice strategies to address perinatal health issues.

MCH provides technical assistance/training to local communities in the use of available data in determining and addressing community needs for prenatal care.

MCH completed development of a database of perinatal health care providers and has developed a database of local breastfeeding service providers.

c. Plan for the Coming Year

Direct Services:

Care coordination will continue through MCH grants to local agencies from KDHE. The provision of medical prenatal services will continue in some communities to address gaps in provider services.

Enabling Services:

MCH will continue to provide local agencies technical assistance in service provision and assist in finding resources. MCH program staff will continue to foster relationships among perinatal healthcare providers, State agencies, businesses, the health insurance industry and other interested partners. MCH, WIC and March of Dimes will continue to work with Healthy Babies in Wichita and support efforts of the Connections Program in Wyandotte County that supports private providers in providing services to large numbers of uninsured.

Population-Based Services:

Early prenatal care outreach will continue through coordination with Family Planning and WIC service providers and the MCH Program. Local MCH grantees will continue education and outreach strategies with guidance and support from MCH program staff.

Infrastructure Building Services:

In order to maximize resources, MCH will continue to build on collaborations with current partners and local obstetrical and perinatal health care providers in order to maximize resources. Support will be provided to programs designed to promote and assure access to early and comprehensive prenatal care and to promote optimal health in the interconception period. MCH staff will continue workforce development efforts and training through the annual Governor's Conference on Public Health and regional home visitation training events. MCH program staff will disseminate best practice information through the perinatal healthcare provider database and provide information from the breastfeeding resources database to interested health care providers.

MCH program staff will provide linkages to best practices and available trainings on promoting healthier birth outcomes among disparate populations and give technical assistance to local agencies.

D. State Performance Measures

State Performance Measure 1: *The percent of women in their reproductive years with public or private health insurance coverage*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			90	90	90
Annual Indicator	83.1	81.8	80.3	82.7	82.7
Numerator	424383	416378	401212	414017	414017
Denominator	510690	509019	499641	500651	500651
Data Source					Kansas BRFSS, 2007
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**

Annual Performance Objective	90	90	90	90	90

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Fall 2009.

Notes - 2007
Source: Kansas Behavioral Factor Surveillance Survey, 2007

Notes - 2006
Source: Kansas Behavioral Factor Surveillance Survey, 2006

a. Last Year's Accomplishments
Direct Services:
Women were assisted in completing application documents for Medicaid and HealthWave (SCHIP) programs by health department staff, Supplemental Nutrition Program for Women, Infants and Children (WIC) staff, school nurses, and home visitation staff.

Enabling Services:
The Kansas Statewide Farmworker Health Program (SFHP) provided outreach and assisted with access to health care for the predominately Hispanic and Low German speaking farm worker population with no insurance.
Healthy Start Home Visitors (HSHV's) supported families by providing information on local resources and assistance in filling out forms for medical services and public assistance.

Population Based Services:
UniCare and Mercy Family Health Partners together administered the managed care programs consisting of HealthWave (Kansas SCHIP). UniCare offered a free service, Maternicall, which allowed pregnant women access to critical prenatal care information to promote healthier pregnancies and birth outcomes provided by a healthcare team led by specially trained Registered Nurses.

Infrastructure Building Services:
The MCH program with its network of statewide partners continued to work toward the priority of comprehensive health care for pregnant women before, during and after birth that was identified in the MCH 2010 Statewide Needs Assessment.

March of Dimes continues to be a major partner in supporting MCH priorities as identified above through programs, outreach and advocacy efforts.

Continue surveillance of the health insurance status of women of reproductive age as an predictor of birth outcome data for the State.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Disseminate information on the availability of Medicaid/HealthWave coverage for pregnant women		X	X	X
2. Promote the importance of preventive health care, comprehensive chronic disease management, and early prenatal care for women in the preconception period.		X	X	X
3. Increase efforts to assist uninsured women to enroll in Medicaid/HealthWave.	X	X	X	X

4. Teach adolescents the importance of reducing risk behaviors of smoking, drinking and other physically harmful lifestyles prior to pregnancy.			X	X
5. Provide outreach and education to hard to reach populations and disparate populations			X	X
6. Promote health insurance coverage availability for all women of childbearing age in the State.				X
7. Work toward obtaining birth spacing waiver				X
8. Healthy mother and babies programs address high-risk disparate populations		X		
9.				
10.				

b. Current Activities
Direct Services:
LHD staff assist women in completing applications for medical assistance programs.

Enabling Services:
The SFHP offers outreach and access to health care for mainly Hispanic and Low German speaking farm workers.

HSHV's provide links to local services for families and assist them in navigating the health care system.

Comprehensive care coordination programs for women and infants are undertaken in both Wyandotte and Sedgwick Counties. Wyandotte County's Connections program primarily focuses on prenatal care whereas the Sedgwick County Healthy Babies program supports both prenatal care topics and other family support services for high-risk families.

Population Based Services:
The Maternicall program through UniCare provides prenatal care information to pregnant women in the Medicaid managed care system.

Infrastructure Building Services:
MCH staff disseminates information on public health issues: access to prenatal care, preconception health and birth spacing in its newsletter to a statewide network of partners.

Surveillance of early and comprehensive prenatal care for women using Behavior Risk Factor Surveillance System (BRFSS) and other data as appropriate.

MCH staff provides to its local agencies the links to information on best practices and funding resources.

In partnership with the KHPA, the MCH advisory councils advocate with policymakers for a birth spacing waiver for Kansas women.

c. Plan for the Coming Year
Direct Services:
Medical prenatal services will continue to be provided in communities with no other source of access for uninsured.

Enabling Services:
The MCH staff will continue to collaborate with the Statewide Farmworker Health program primarily in services for the Hispanic and Low German speaking population and uninsured.

MCH staff will link partners with providers of services for medically underserved populations.

Local Health Department (LHD) staff will provide community resource information to women with new infants on the availability of state health insurance programs and assist with enrollment. Also, LHD staff will offer information on how to access family planning services.

Continue support of the Wyandotte and Sedgwick County prenatal programs.

Population Based Services:
MCH staff will promote to local agencies and partners, the Unicare Maternicall system (telephone prenatal support to pregnant women enrolled in Medicaid managed care).

Infrastructure Building Services:
The ZIPS newsletter produced by MCH program staff will continue to serve as a means of providing best practice and current program information to its grantees and partners.

MCH staff will disseminate to its grantees and partners information on how women can achieve healthier birth and infant outcomes including preconception health strategies and adequate birth spacing (promotion of national Web casts, recommendations on preconception health from the CDC/ATSDR Preconception Work Group and the Select Panel on Preconception Care and linkages to best practice on partnering Web sites).

MCH staff will continue to monitor BRFSS data on health insurance coverage for women 18-44 and advocate for expanded Medicaid coverage. Analyze the State health insurance database for prenatal care access data as these relate to disparate populations.

MCH staff will encourage its grantees and partners to participate in cultural diversity trainings as they become available and monitor for implementation into the practice setting.

MCH staff will promote community collaborations that improve access to prenatal care.

The MCH council work will advocate with policymakers for a birth spacing waiver for Kansas women.

State Performance Measure 2: *The percent of women who report cigarette smoking during pregnancy*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			11	16	16
Annual Indicator	12.4	16.3	16.5	16.1	16.1
Numerator	4906	6475	6729	6767	6767
Denominator	39553	39701	40896	41951	41951
Data Source					Kansas Vital Statistics, 2007
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	15.8	15.5	15.3	15.3	15.3

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Fall 2009.

Notes - 2007
Data Source: Birth certificate (resident) data, 2007, Center for Health & Environmental Statistics, KDHE

Data prior to 2005 are not comparable due to the revision of the Kansas Birth Certificate.

Notes - 2006
Data Source: Birth certificate (resident) data, 2006, Center for Health & Environmental Statistics, KDHE

Data prior to 2005 are not comparable due to the revision of the Kansas Birth Certificate.

a. Last Year's Accomplishments
Cigarette smoking during pregnancy adversely affects the health of both mother and child. It increases the risk for adverse maternal conditions and poor pregnancy outcomes. Infants born to mothers who smoke weigh less than other infants, and low birth weight (<2,500 grams) is linked with infant mortality. In Kansas, 2007, 16.1% (6767) of women reported smoking during pregnancy, a 2.4% decrease from 2006. This decrease was not statistically significant. Over the three year period (2005-2007), there was no significantly increasing or decreasing trend detected. Among women who reported smoking during pregnancy, 50.3% reported Medicaid as principal source of payment for this delivery.

Direct Services:
Tobacco cessation assistance was provided to pregnant women referred to the Kansas Tobacco Quitline (Quitline) and through local tobacco cessation clinical provider services.

Enabling Services:
MCH grantee prenatal care coordinators were encouraged to assess all pregnant women for tobacco use and provide education on the risks associated with continued tobacco smoking and either provided services or referred them to services to aid in tobacco cessation.

Population Based Services:
MCH staff encouraged grantees and partners to pursue available tobacco cessation training, provide smoking cessation opportunities to pregnant women and refer them to the Quitline for follow-up support services.

Infrastructure Building Services:
Prenatal care providers were encouraged to participate in updates from the National Partnership to Help Pregnant Smokers Quit telephone conferences.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Encourage tobacco cessation training by all prenatal service providers.		X	X	X
2. Provide relevant tobacco cessation materials and resources to local agencies.		X	X	X
3. Educate and encourage all pregnant women who smoke to discontinue smoking during pregnancy.	X		X	X
4. Prevent smoking behavior in preconceptional women and adolescents.	X		X	X
5. Use 5A's Smoking Cessation method with added support from the Quitline as a standard protocol for all MCH grantee providers			X	X

of prenatal service to women who smoke.				
6. Collect and analyze smoking data from all MCH grantees.			X	X
7. Provide technical assistance on billing to develop program sustainability.				X
8. Monitor relevant tobacco/smoking ordinances and legislation with other KDHE staff and partnering tobacco-free coalitions.				X
9.				
10.				

b. Current Activities

Direct Services:
Tobacco cessation assistance is provided to pregnant women referred to Quitline and through local tobacco cessation clinical provider services.

Enabling Services:
Prenatal care providers and MCH grantee agencies are given relevant tobacco cessation information/resources through newsletter articles and in other communications.

MCH local agencies provide information on available community resources for smoking cessation to pregnant women and members of their households.

Population Based Services:
MCH prenatal care coordinators provide screening, counseling and referral to the Quitline or local tobacco cessation services for pregnant women. Also, LHD staff report birth outcome and health risk behavior data (smoking) as measures of program performance.

Infrastructure Building Services:
MCH staff and the Kansas Tobacco Use Prevention Program (TUPP) encourages local agencies to refer pregnant women to the Quitline and other tobacco cessation materials.

The Kansas TUPP disseminates an annual report that evaluates the efforts of participating organizations implementing the 5 A's approach and other tobacco-related issues.

In addition, MCH grantees and other providers are encouraged to participate in the National Partnership to Help Pregnant Smokers Quit telephone conferences.

Smoke-free ordinances have been passed in 35 cities in Kansas with three county smoke-free resolutions in Johnson, Pratt and Harvey Countie

c. Plan for the Coming Year

Direct Services:
Tobacco cessation assistance will continue to be provided to pregnant women utilizing the 5A's Tobacco Use prevention method through local tobacco cessation clinical provider services and via referral to the Quitline.

Enabling Services:
Local prenatal care providers and MCH programs will continue to receive relevant tobacco cessation information/resources via newsletter articles and routine communications from MCH Program staff. Also, they will participate in phone conference updates from the National Partnership to Help Pregnant Smokers Quit.

Kansas home visitation staff will continue to provide information about available community tobacco cessation resources to pregnant women and their families to address this issue.

MCH Program staff will continue to encourage local agency staff to screen all pregnant women

for smoking behavior and tobacco use and provide education on the health risks to mother and infant associated with continued smoking. Also, local agency staff will be encouraged to continue making referrals to local tobacco cessation services or to the Quitline.

Population Based Services:
MCH programs will continue to be encouraged to implement systematic changes in their clinics with a focus on tobacco cessation and provide data on their progress.

Infrastructure Building Services:
Some capacity is in place to provide smoking cessation counseling and referral by prenatal service providers in the state. MCH staff will continue to engage prenatal providers and safety net clinics to engage in tobacco cessation activities for pregnant women.

MCH staff will continue to monitor data related to smoking behaviors and tobacco use.

MCH staff will continue to provide technical assistance to local grantee agencies regarding billing for tobacco cessation counseling in an effort to support sustainability. Currently Medicaid does not pay for tobacco cessation counseling. Medicaid does pay for the Zyban and Chantix patch but does not pay for the gum, spray, inhaler, or lozenge. MCH staff will continue to encourage Medicaid reimbursement for tobacco cessation counseling.

MCH staff will continue to work with local, regional and state-level stakeholder organizations to implement prenatal smoking cessation activities.

MCH staff will continue to monitor, in collaboration with the Kansas TUPP and partnering tobacco-free coalitions, ordinances and legislation regarding smoking/tobacco use.

State Performance Measure 3: *The percent of mothers who breastfeed their infants at least 6 months*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			25	26	27
Annual Indicator	38.2	37.8	42.3	42.1	42.1
Numerator					
Denominator					
Data Source					National Immunization Survey
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	50	50	50	50	50

Notes - 2008
The 2008 column is populated with 2007 data. Estimates for children born in 2006 will be available in August 2010.

Notes - 2007
Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services.

Final geographic-specific breastfeeding rates among children born in 2005, CDC's Breastfeeding National Immunization Data: Any by States: 2005.

http://www.cdc.gov/breastfeeding/data/NIS_data/2005/state_any.htm

Notes - 2006
Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services.

Final geographic-specific breastfeeding rates among children born in 2004, CDC's Breastfeeding National Immunization Data: Any by States: 2004.

http://www.cdc.gov/breastfeeding/data/NIS_data/2004/state_any.htm

a. Last Year's Accomplishments
In the 2007 provisional National Immunization Survey, 43.4% of Kansas children born in 2005 were breastfed at least 6 months, 2.6% higher than in 2006 (42.3%). This compares to 43.1% for the U.S. This estimate is getting closer to, but remains below the national Health People 2010 objective (50%). Over the six year period (2000-2005), there is a significantly increasing trend ($p<0.05$) in the percents of Kansas mothers who breastfed their infants at 6 months of age. The survey also shows that low income mothers are less likely to breastfeed than their higher income counterparts are.

According to the 2007 Pediatric Nutrition Surveillance System (PedNSS), which assesses breastfeeding status of children from low-income families (below 185% of poverty level) participating in WIC, 21.6% of WIC infants were breastfed at least 6 months, 2.7 % lower than in 2006 (22.2%). This was 15.0% lower than the percent for U.S. mothers (25.4%). This is well below the HP 2010 objective. Over the 8 year period (2000-2007), there is no statistically significant increasing or decreasing trend in the percents of WIC participant mothers who breastfed their infants at 6 months of age.

Enabling Services:
Continued the statewide breastfeeding public awareness campaign by maintaining breastfeeding support billboards in three prominent locations along the Kansas Turnpike and other busy Kansas highways.

Developed and distributed a series of "Breastfeeding Reminder Post Cards" and a Crib Card in coordination with the Breastfeeding Taskforce.

Worked with Medela to provide "Breast Pump 101" seminars in three locations in Kansas for LHD WIC staff and MCH staff.

Established the Kansas Breastfeeding Coalition. This coalition is made up of a wide variety of health care professionals and breastfeeding supporters across the state.

Maintained a lactation room that is available for all nursing women who are employed in the Curtis State Office Building.

Population-Based Services:
Provided all local agencies with a packet of ideas to help with the promotion of World Breastfeeding Week (WBW) activities in August 2008. Two agencies were awarded $200 worth of breastfeeding education and/or resource materials for outstanding promotion efforts.

Infrastructure Building Services:
Supported Breastfeeding Peer Counselor Programs in 19 Kansas counties. Peer counseling is a significant factor in improving breastfeeding initiation and duration rates among women in a variety of settings, including economically disadvantaged and WIC populations.

Supported Certified Breastfeeding Educator Training in April 2008.

State and local staff attended the USBC biennial conference in January 2008 and the NWA Nutrition and Breastfeeding Conference in September 2008. Provided twelve clinic staff with stipends to attend the NWA training in September.

Quarterly breastfeeding packets including a newsletter to share with other health professionals and new breastfeeding resources were distributed to 104 locations throughout the state.

Worked with the Governor's Child Health Advisory Board to develop breastfeeding workplace support policies and lactation room development guidelines. Completed policies and guidelines were forwarded to the Governor's Office for action.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support state agencies, LHD and private businesses to implement new or enhance existing breastfeeding friendly worksite policies.				X
2. Build and enhance relationships among community, public, non-profit and private sectors at the community, county and state level that support breastfeeding.		X		
3. Provide or support evidence-based continuing education on breastfeeding promotion and support.				X
4. Support breastfeeding credentialing efforts of LHD staff for both MCH and WIC programs.				X
5. Sustain a statewide public awareness campaign that supports breastfeeding.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Enabling Services:
Continue the statewide breastfeeding public awareness campaign with an emphasis on breastfeeding in the workplace.

Design and disseminate breastfeeding evaluation tools which are available to all local health departments and school nurses.

Work with the Kansas Breastfeeding Coalition (KBC) to enhance existing relations among public and private partners.

Support implementation of the KBC's Business Case for Breastfeeding Grant.

Increase access to breastfeeding resources.

Population Based Services:
Coordinate a public awareness campaign for World Breastfeeding Week in August 2009. Provide all clinics who submit a summary of their activity with up to $75 worth of breastfeeding education and/or resource materials.

Infrastructure Building:
Build the capacity of leaders and members from all sectors of the community by supporting Certified Breastfeeding Educator Training in October 2008.

Promote quality training and/or credentialing of health professionals involved in breastfeeding promotion and support by providing information about upcoming educational opportunities, stipends to attend and underwriting speakers on breastfeeding topics for the statewide conferences.

Support evidenced-based breastfeeding related training of researchers and practitioners by distributing breastfeeding packets throughout the state. The packets will include a newsletter and breastfeeding resources which can be shared with other health professionals in their communities.

c. Plan for the Coming Year
Enabling Services:
Continue the statewide breastfeeding public awareness campaign with billboards.

Support existing Breastfeeding Peer Counselor Program.

Build and enhance relationships among community, public, non-profit and private sectors at the community, county and state level that support breastfeeding.

Population Based Services:
Coordinate a public awareness campaign for World Breastfeeding Week in August 2010 by providing all local agencies with a packet of ideas to help with the promotion of WBW and provide participating agencies with breastfeeding education and/or resource materials.

Infrastructure Building:
Work with LHD to improve staff competencies related to breastfeeding, including helping to sponsor Certified Breastfeeding Educator Training in at least one location.

Promote quality training and/or credentialing of health professionals involved in breastfeeding promotion and support by providing information about upcoming educational opportunities, stipends to cover registration and underwrite speakers on breastfeeding topics for the statewide conferences, including provision of the USDA's Loving Support Breastfeeding training to local clinic staff.

Support evidenced-based breastfeeding related training of researchers and practitioners by distributing breastfeeding packets throughout the state. The packets will include a newsletter and breastfeeding resources which can be shared with other health professionals in their communities.

Increase the number of settings where appropriate breastfeeding information can be accessed by health professionals, interested partners and breastfeeding families by supporting the development of a website for the Kansas Breastfeeding Coalition.

State Performance Measure 4: *The percent of children and adolescents that receive behavioral/mental health services*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**

Annual Performance Objective			6	7	7
Annual Indicator	4.9	5.0	5.4	6.0	6.1
Numerator	41411	41701	46970	51407	52606
Denominator	852755	842406	862298	861972	861972
Data Source					Kansas Community Health Centers
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	8	8	8	8	8

Notes - 2008
Data Source: Kansas Community Health Centers, 2008 (Provisional data)

Notes - 2007
Data Source: Kansas Community Health Centers, 2007

Notes - 2006
Data Source: Kansas Community Health Centers, 2006

a. Last Year's Accomplishments
The Healthy People 2010 objectives relevant to this SPM are found in Focus Area 18 Mental Health and Mental Disorders. The goal is to improve access to behavioral and mental health services for children and adolescents. Two of the HP2010 objectives on mental health which Kansas will address with MCH grant funds are: Objective 18-6: Increase the number of persons seen in primary health care who receive mental health screening and assessment and Objective 18-7: Increase the proportion of children with mental health problems who receive treatment (Developmental).

The 1999 Surgeon General's Report on mental health indicates that about 20 percent of children have mental disorders with at least a functional impairment. Additionally, about 11% of these children are diagnosed, but not treated.

School failure, substance abuse, violence, and suicide are potential outcomes of mental and behavioral disorders and serious emotional disturbances (SEDs). Kansas Youth Risk Behavior Survey (YRBS) data identified 21.0% in 2005 compared to 20.6% in 2007 students smoked cigarettes during the past 30 days; 43.9% drank alcohol during the past 30 days in 2005 compared to 42.4% in 2007; 15.6% used marijuana during the past 30 days in 2005 compared to 15.3% in 2007; 6.0% used ecstasy one or more times during their life in 2005 compared to 8.6% in 2007; 21.4% of students who felt so sad or hopeless almost every day for 2 or more weeks in a row that they stopped doing some usual activities during the 12 months in 2005 compared to 25.0% in 2007; and 6.5% attempted suicide during the past 12 months in 2005 compared to 6.7% in 2007.

Direct Services:
Some Kansas schools used the telemedicine network from Kansas University Medical Center (KUMC), connecting students to mental health counseling with age appropriate mental health providers and psychiatrists.

MCH grantees included the use of the Bright Futures in Practice, Mental Health guidance materials to include mental health screening when providing basic EPSDT screenings.

Enabling Services:

MCH staff collaborated with Kansas Juvenile Justice Authority, Coalition Against Sexual and Domestic Violence, University of Kansas Medical Center, Kansas Children's Cabinet, Head Start, Child Support Services, Kansas Parent Information & Resource Center, Social and Rehabilitation Services (SRS), to sponsor the Annual Statewide Fatherhood Summit. The summit had a multicultural theme with African American, American Indian, Hawaiian, Latino as well as military and formerly incarcerated fathers speaking about their culture, customs and experiences as these relate to behavioral/mental health issues.

Population Based Services:
Increased numbers of children and youth were screened for mental health screening as a result of training provided to professional educators through Kansas State Department of Education (KSDE).

Infrastructure Building Services:
MCH staff served on the Governor's Mental Health Services Planning Council (GMHSPC). The Council's goal was to develop a mental health plan for the state.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Screen all children for behavioral/mental health issues at KAN Be Healthy (EPDST) visits that are done in MCH clinics & by providers.	X	X	X	X
2. Create awareness of usable tools for screening and guidance available in Bright Futures in Practice Mental Health for providers in Kansas.		X	X	X
3. Participate in the GMHSPC and assist in critiquing a mental health plan for Kansas.			X	X
4. Continue collaboration with the group and organizations that support improved mental health access and implementation.				X
5. Provide education for school personnel and MCH grantees on identification of mental health illness signs and symptoms and referral resources.		X	X	X
6. Prepare information for distribution on training school/community members on how to establish Students Against Destructive Decisions (SADD) organizations in their schools.		X	X	X
7.				
8.				
9.				
10.				

b. Current Activities
Direct Services:
Some school districts provide individual and family therapy through the regional mental health centers and telemedicine offered through KUMC.

Enabling Services:
The Assuring Better Child Development Plus (ABCD+) group formed and is developing an internet-based directory of mental health services for children as a referral resource for providers identifying children in need of services.

Population-Based Services:

The Annual Statewide Summer Conference for Kansas School Nurses provided education on bullying, cyber-bullying and online safety. MCH grantees were provided information on the six risk behaviors of teens at the Annual Governor's Public Health Conference.

MCH staff collaborated with Students Against Destructive Decisions (SADD) and the Kansas National Guard to provide Healthy Habits of Successful Teens session at the annual SADD training.

Infrastructure Building Services:
Initiated work on recommendations for standard of care relating to mental health screening in Kansas schools. National Association of Mental Illness (NAMI) gave Kansas an "F" grade in 2006. This was upgraded to a "D" in 2009 due to improvements in developmental screening as a routine component of EPSDT (ABCD project) and the GMHSPC strategic plan for mental health.

c. Plan for the Coming Year
Direct Services:
All children, birth to 21 years of age will receive both developmental and mental health screening at each KAN Be Healthy (EPSDT) assessment.

Enabling Services:
Will continue support of the GMHSPC with emphasis on early identification and treatment of mental health issues in the school age population and utilizing the telemedicine network.

Population-Based Services:
The Annual Kansas School Nurse conference will continue to educate school nurses and provide tools to identify and refer at-risk students for mental and behavioral health interventions.

Information on mental health issues will be included in the MCH Zero to age 21: Information Promoting Success (ZIPS) newsletter.

MCH staff will continue to support and serve on the planning committee for the Fatherhood Summit.

MCH staff will work with KSDE staff and other stakeholders to plan and hold an Adolescent Health Summit that will include mental health issues.

Infrastructure Building Services:
MCH staff will continue work with GMHSPC to improve Kansas' NAMI grade.

The Assuring Better Child Development Plus (ABCD+) group will provide training to providers on mental health screening and disseminate information on the internet-based directory of mental health services for children as a referral resource for the providers identifying children in need of services.

Increase collaboration efforts with stakeholders and provide a strong leadership voice for children and adolescent mental health across Kansas.

State Performance Measure 5: *The percent of children who are overweight*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2004	2005	2006	2007	2008

Data					
Annual Performance Objective	6	12	12	11.5	11.5
Annual Indicator	13.6	12.9	13.8	13.6	13.6
Numerator	4020	4306	3092	4281	4281
Denominator	29559	33378	22404	31476	31476
Data Source					Kanas PedNSS, 2007
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	11	11	10.5	10.5	10.5

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Fall 2009.

Notes - 2007
Data Source: Pediatric Nutrition Surveillance System (PedNSS), 2007, Kansas WIC data of children, ages 2-<5, used as a proxy measure.

Notes - 2006
Data Source: Pediatric Nutrition Surveillance System (PedNSS), 2006, Kansas WIC data of children, ages 2-<5, used as a proxy measure.

The numbers presented for 2006 do not represent all the WIC participants due to a new data base roll-out.

a. Last Year's Accomplishments
According to the 2007 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families (below 185% of poverty level) participating in WIC, 13.6% of low-income children ages 24-59 months in Kansas were overweight, 8.7% lower than WIC participants nationally (14.9%). Over the 8 year period (2000-2007), there is a statistically significant increasing trend ($p<0.05$) in the percent of WIC participants overweight.

Enabling Services:
Worked with the Office of Health Promotion to promote a statewide event focused on increasing physical activity among 3rd grade students. The event was held May 2, 2008 with approximately 17,600 participants at 40 sites located throughout the state.

Worked with the Governor's Food Security Task force to develop and provide LHD with a guide to Kansas Food Resources to assure access to healthy food choices.

Population Based Services:
School nurses were surveyed to assess if school aged children are being weighed, measured and referred, as appropriate. Data were inconclusive and data gathering methods will be changed for next year's survey. The importance of assessing height, weight and BMI's of school aged children was covered in newsletters and trainings targeting school nurses.

Infrastructure Building Services:
As a part of the action plan developed by the Kansas USDA nutrition programs, three communities held community wide events to increase healthy eating behaviors. Incentives to increase physical activity and encourage healthy eating behaviors were provided to event participants.

Worked with the Coordinated School Health program, Blue Cross and Blue Shield Foundation of Kansas, Healthy Kids Kansas and Community Health Assessment to assist communities, child care facilities and schools in obtaining grants for communities to use to address healthy eating

and physical activity.

LHDs were encouraged to attended the October 2007 Built Environment summit.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assure access to a food supply and healthy food choices.			X	
2. Assure access to safe, affordable opportunities to be physical active.			X	
3. Identify funding resources and partners.		X	X	
4. Utilize and improve data systems.		X	X	X
5. Use and communicate results of program and policy interventions that contribute to evidence-based strategies.				X
6. Increase the number of well-trained MCH personnel who support healthy eating and physical activity.		X	X	
7. Promote consistent messages with best evidence available.				
8.				
9.				
10.				

b. Current Activities

Enabling Services:
Continue working with the Office of Health Promotion to promote the Kansas Kids Fitness Day, a statewide event focused on increasing physical activity among 3rd grade students in Kansas.

Develop and disseminate a list of training websites and resources that promote good nutrition and physical activity for use by LHD staff.

Population Based Service:
Survey school nurses to assess if school aged children are being weighed, measured and referred, as appropriate.

Promote increased intake of fruits and vegetables by implementing the new WIC food packages.

Infrastructure Building Service:
Facilitate MCH staff in obtaining continuing education to promote, deliver and evaluate services to support healthy eating and physical activity by encouraging attendance at the Symposium on Adolescent Health Issues.

State staff will attend CDC's Weight of the Nation Conference and the Annual Meeting of the Association of State and Territorial Public Health Nutrition Directors for training on evidence-based research approaches, methods and policy development.

Provide training on community-based participatory research approaches by encouraging LHD staff to attend the 2008 Built Environment Summit.

Work with the Coordinated School Health program, Blue Cross and Blue Shield Foundation of Kansas, Healthy Kids Kansas and Community Health Assessment to assist communities, child care facilities and schools in obtaining grants for communities to use to address healthy eating and physical activity

c. Plan for the Coming Year

Enabling Services:
Model health education and physical activity for 3rd grade students in Kansas, by working with the Office of Health Promotion to promote the Kansas Kids Fitness Day, a statewide event focused on increasing physical activity among 3rd grade students in Kansas. Nearly half of all third graders in the state of Kansas participate each year.

Promote the use of existing online staff educational programs that promote good nutrition and physical activity.

Population Based Service:
Survey school nurses to assess if school aged children are being weighed, measured and referred, as appropriate. Importance of assessing these parameters will be covered in newsletters and trainings.

Work with the Office of Health Promotion and other stakeholders to design and promote a consistent and culturally appropriate nutrition and physical activity messages.

Infrastructure Building Services:
Assist LHDs in identifying and accessing funding streams that could potentially support nutrition and physical activity programs at the community level.

Strengthen processes and mechanisms to assist LHD in successful grant writing by identifying online training resources and workshops or through support of speakers at public health conferences.

Enhance the socioeconomic development, organization and project management, policy research, and meeting facilitation and data collection and evaluation in state and local programs.

Increase the number of well-trained MCH staff who plan, facilitate, deliver and evaluate healthy eating and physical activity messages. Use and communicate education gained from CDC's Weight of the Nation Conference, the Annual Meeting of the Association of State and Territorial Public Health Nutrition Directors and other national meetings to LHDs.

State Performance Measure 6: *The rate of adolescent deaths due to motor vehicle crashes when using no seat belt*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			20	13	12.5
Annual Indicator	17.2	13.4	14.3	13.9	13.9
Numerator	35	27	29	28	28
Denominator	203322	201966	202458	201815	201815
Data Source					Fatal Accident Reporting System
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12	11.5	11	11	11

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Summer 2009.

Notes - 2007
Data Source:
Numerator = Fatal Analysis Reporting System (FARS), U.S. Department of Transportation Data. http://www-fars.nhtsa.dot.gov/Main/index.aspx.
Denominator = U.S. Census estimates, Bridged-Race Vintage data set

Notes - 2006
Data Source:
Numerator = Fatal Accident Reporting System (FARS), U.S. Department of Transportation Data
Denominator = U.S. Census estimates, Bridged-Race Vintage data set

a. Last Year's Accomplishments
In 2007, unintentional injury was the leading cause of death for Kansas' adolescents ages 15 to 19 with motor vehicle crashes (MVC) causing the majority of deaths. According to Kansas FARS (Fatal Accident Reporting System) data, from 2003-2007, there is a decreasing trend (statistically not significant) in deaths due to motor vehicle crashes where the occupant was not wearing a seat belt. However, over the 9 year period (1999-2007), there is a significantly decreasing trend ($p < 0.05$).

The adolescent death rate due to motor vehicle accidents without using a seatbelt is 42.0% higher for Kansas (13.9%) than for the U.S. (9.8%). In Kansas between 2006 and 2007, there was a 3.1% decrease in motor vehicle crash deaths where the youth was not wearing a seat belt. Kansas 2007 YRBS data showed that 15% of high school students never or rarely wore a seatbelt. Kansas Department of Transportation (KDOT) data for 2007 showed 75% of teens (ages 15-18) that died as a result of a motor vehicle crash were not using seat belts and teen drivers account for 6% of all KS registered drivers but 18.0% of all MVCs.

Suggested reasons for Kansas' higher MVC rate include teen drivers don't believe they will be involved in a MVC thus do not buckle up. In the more remote rural areas in Kansas, there is a higher fatality rate than urban possibly because the MVC is not immediately discovered and emergency response may be delayed and possibly experience/training of responders (mostly volunteers).

KDOT says the top five contributing circumstances for fatalities are inattention, speed, alcohol, failure to yield and, disregard for road signs, markings. Among 118 alcohol-related deaths in 2007, 23 deaths were to drivers under age 21. The Youth Risk Behavior Survey (2007) indicates that 31% of Kansas students (grades 9-12) reported within the previous 30 days they rode with a driver who had been drinking alcohol and 15% reported they drank alcohol and drove within the previous 30 days.

Enabling Services:
School nurses were provided information on the recently enacted Kansas statutes that address underage drinking and social hosting at the Annual Statewide Summer Conference for Kansas School Nurses.

Population-Based Services:
KDOT initiated the Kansas Traffic Safety Resource Office (KTSRO) to reduce drinking drivers, promote prevention of underage alcohol consumption and enhance safe driving activities. MCH staff works with KTSRO and the Kansas Highway Patrol, local law enforcement, the Kansas Drivers Safety Education Association(KDSEA), American Automobile Assoc. (AAA), Kansas Safe Kids Coalitions, the Kansas Family Partnership, Students Against Destructive Decisions (SADD) and others to provide adolescent focused traffic safety education.

Infrastructure Building Services:
MCH staff collaborated with the above mentioned coalitions and agencies to support legislation for a graduated driver's license and primary seat belt law but unfortunately neither issue passed this session.

The Kansas Trauma Program with KDHE developed a statewide trauma plan with emphasis on rural first response.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote seat belt usage by adolescents through support of legislation and local efforts to increase compliance with seat belt usage.	X	X	X	X
2. Formulate work plans with State SADD leadership to increase incentives for SADD chapters to promote seat belt use among teens.		X	X	X
3. Discuss seat belt usage as anticipatory guidance with all adolescents receiving a Kan-Be-Healthy service in MCH clinics.		X		X
4. Make available technical assistance to school nurses how they can decrease MVCs in their communities by using resources available with the KTSRO and SADD.			X	X
5. Serve on the advisory board for Leadership to Keep Children Alcohol Free, and examine the effectiveness of initiatives used across KS to decrease drinking and driving.			X	X
6. Write articles for the KDHE and Children & Family Section newsletter informing readers of the benefits and engage them to help remind teens to use seat belts.			X	X
7. Explore and provide training using tools to help engage teens to use good decision making skills for life choices.			X	X
8.				
9.				
10.				

b. Current Activities
Enabling Services:
The Kansas State Department of Education (KSDE) continues to administer Safe and Drug-Free Schools and Communities Act Grant Program in 16 schools and community projects.

Population Based Services:
MCH staff supports and promotes the Kansas Traffic Safety Resource Office (KTSRO), Kansas Highway Patrol, local law enforcement, the Kansas Drivers Safety Education Association(KDSEA), American Automobile Assoc. (AAA), Kansas Safe Kids Coalitions, the Kansas Family Partnership, Students Against Destructive Decisions (SADD) and others to provide adolescent focused traffic safety education and prevention programs.

Kansas Medical Emergency Services (KMES) provided the School Nurse Emergency Medical Services for Children Program (SNEMS-C) for 52 nurses at the Annual Statewide Summer Conference for Kansas School Nurses as a post conference session for 52 school nurses.

Infrastructure Building Services:
The graduated driver's license passed the Kansas Legislature and became law. It includes restrictions on the use of wireless devices while operating a vehicle.

MCH staff continues to work with KSDE staff regarding program development and positive decision-making skills for adolescents.

The Kansas Trauma Program provides training to the six regions in Kansas offering rural specific trauma courses to reduce morbidity and mortality and to improve emergency response outcomes.

c. Plan for the Coming Year

Enabling Services:
Students Against Destructive Decisions (SADD) and Kansas Family Partnership's Red Ribbon training will be provided to teens across Kansas through the sponsoring agencies.

Population Based Services:
MCH staff will partner with Kansas State Department of Education (KSDE) staff to offer an Adolescent Symposium for Kansas educators on adolescent unintentional injury and preventative measures.

Infrastructure Building Services:
MCH staff will continue to support school districts that participate in Youth Risk Behavior Surveillance.

MCH staff will continue to collaborate with outside agency resources in developing strategies that promote seat belt usage by adolescents to decrease the incidence of unintentional morbidity and mortality. MCH staff formulate work plans with State SADD leadership to increase incentives for SADD chapters to promote seat belt use among teens.

MCH grantees will discuss seat belt usage as anticipatory guidance with all adolescents receiving a Kan-Be-Healthy service in MCH clinics.

MCH staff will provide technical assistance to school nurses about how they can decrease MVCs in their communities by using resources available with the KTSRO and SADD and explore and provide training using tools to help engage teens on good decision making skills for life choices.

MCH staff will serve on the advisory board for Leadership to Keep Children Alcohol Free, and examine the effectiveness of initiatives used across KS to decrease drinking and driving.

Provide education through the C&F newsletter on promotion of adolescent seat belt use.

Kansas Trauma Program (KTP) will utilize a data collection system that collects data on all trauma patients in Kansas that meet a case definition. KTP will be working with Kansas Department of Transportation (KDOT) in developing a Strategic Highway Safety Plan that will include data from the trauma registry. Current data shows that those teens in a motor vehicle crash (MVC) not wearing a seat belt have a higher injury severity score (ISS). The non-belted are more severely injured than those that are belted. One area of interest is to evaluate higher injury severity scores with increased costs.

State Performance Measure 7: *The percent of infants with special health care needs who receive care within a medical home*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2004	2005	2006	2007	2008

Data					
Annual Performance Objective			65	65	85
Annual Indicator	58.9	58.9	58.9	82.1	87
Numerator					
Denominator					
Data Source					KS CSHCN infant survey 2008
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	88	89	91	92	92

Notes - 2008
DATA SOURCE: Data is based on returned surveys mailed to families identified by the Kansas Vital Records as having birth defects and requested further information from the Bureau of Family Health. Data prior to 2007 is not comparable because of differences in data sources and methods.

Notes - 2007
Data Source: Survey from families with high risk infants using the vital export file, October 2007 - July 2008. Data prior to 2007 are not comparable due to differences in data source

Notes - 2006
The 2006 data are not available - plan to survey families with high risk infants using the vital export file.

The estimate (58.9%) is based on the 2001 national CSHCN survey: CSHCN (age 0-17) received coordinated ongoing comprehensive care within a medical home.

a. Last Year's Accomplishments
Direct Services:
Data for this performance measure is from the Vital Statistics birth defects export
File. Refining the birth defects reporting system is still in progress. The export file contains data on infants with congenital anomalies, low birth weights, and low Apgar scores.

Enabling Services:
A letter was mailed to families of infants identified as high risk or having a birth defect. The letter provided information about resources including the CSHCN program, early Intervention services, WIC, insurance, family support organizations, and oral health. Families were encouraged to mail back a postcard with contact information if they had questions to enable us to provide ongoing support.

Population based services:
To assure families with infants receive care within a medical home, letters were generated to this specific population of families identified via the birth defects reporting system.

Infrastructure Building Services:
Staff continue to collaborate with Vital Statistics on elements needed to more efficiently share data via the new birth defects reporting system. Information is being collected on the number of postcards returned and the interventions provided.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Data is being collected to determine if this state priority is being addressed through other established program agendas.	X	X	X	X
2. Follow up phone calls are made to families requesting additional information.	X	X	X	
3. Program development continues to promote information sharing in a timely and HIPAA approved manner between agencies serving the same population.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct Services:
No letters have been sent out since December, 2008 due to electronic configuration issues during the birth defects registry upgrade.

Enabling Services:
Only 4 cards were returned in the prior 6 month time frame and all infants had been seen by their primary care providers.

Population-Based Services:
Hospital discharge planning teams are charged with making referrals to primary care providers and assuring a safe discharge has been arranged. Over the past two years, all returned postcards indicated the family had a medical home provider.

Infrastructure:
This project has not generated the data and enrollment that was anticipated. This state performance measure will be reviewed at the Five Year Needs Assessment.

c. Plan for the Coming Year

Direct Services:
Project is pending configuration access to the birth defects registry

Enabling Services:
No new activities are planned at this time.

Population-Based Services:
Hospital discharge teams continue to assure consistency in hospital to home discharge planning.

Infrastructure Building Services:
Knowledge about the scope of high risk or at-risk children can provide proactive rather than reactive intervention planning; however, the current method has not generated the information expected and needed. Stakeholder input during the Five Year Needs Assessment process will determine if this state priority continues, and if so, how this data can/will be collected.

State Performance Measure 8: *The percent of youths with special health care needs who receive transition services to adult medical care*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			60	60	60
Annual Indicator	46.6	47.1	47.1	47.1	47.1
Numerator					
Denominator					
Data Source					National CSHCN 2005-2006. est KS
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	65	65	65	65

Notes - 2008
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006. Percentage of CSHCN (ages 12-17) whose doctors discussed shift to adult provider, if necessary.

Data for 2008 is not available. 2005-2006 data was used to pre-populate this performance measure. This measure is derived from several questions that have undergone substantial alterations, additions, and changes in skip pattern. Two questions were removed and several new questions were added to address concepts not measured in 2001 and therefore, this indicator is not comparable with pre 2005 data.

Notes - 2007
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06; Percentage of CSHCN (ages 12-17) whose doctors discussed shift to adult provider, if necessary.

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measure. In 2005-06, substantial changes and additions were made to the set of questions and skip patterns used for this outcome. Two questions were removed and several new questions were added to address concepts not measured in 2001. Indicator is not comparable across survey years.

Notes - 2006
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06; Percentage of CSHCN (ages 12-17) whose doctors discussed shift to adult provider, if necessary.

In 2005-06, substantial changes and additions were made to the set of questions and skip patterns used for this outcome. Two questions were removed and several new questions were added to address concepts not measured in 2001. Indicator is not comparable across survey years.

a. Last Year's Accomplishments
Direct Services:
CSHCN staff met with families at specialty clinics sharing information and service resources, providing anticipatory guidelines, and communicating with community supports as approved by families.

Enabling Services:
The CSHCN program has multi-disciplinary transition clinics for older youth in order to address transition issues (Cleft lip/palate, Cerebral Palsy, Cystic Fibrosis, and Spinal Cord). CSHCN staff continue to use the timeline that was developed by the Children Have Opportunities in Inclusive Communities Environments and Schools (CHOICES). The CHOICES Project assists families with early transition issues from toddler age through adolescence. Some topics discussed at CSHCN specialty clinics included: guardianship at age 18 for those unable to make their own decisions; medical care in family practice after the child ages out of pediatric services; SSI/insurance/ Medicaid coverage after age 21; independent living options if appropriate; post high-school education; referral to Rehabilitation Services (formally Vocational Rehabilitation), if appropriate. Transition toolkits in English and Spanish are located in the waiting areas of the specialty clinics to encourage families, with children of any age, to have discussions about transition planning. A list linking to web based transition tools and resources was provided as a take-home directory.

Population Based Services:
The Kansas State Department of Education (KSDE), in coordination with other state programs, conducted the annual transition conference. Families Together, Inc. also provided transition conferences in targeted regions of the state. CSHCN staff participated in these events.

Youth Empowerment Academy conducted a week long "Youth Leadership Forum" allowing YSHCN to experience college campus life, meet with legislative members, and develop action plans to meet their individual goals and objectives. These programs allowed YSHCN to network with other YSHCN and strengthen bonds for future youth involvement in policy and advocacy events. CSHCN was a stakeholder in the Initiative to implement Medical Homes in Kansas. Addressing transition barriers for youth transitioning from pediatric to adult service providers is one of the Initiative's components.

Infrastructure Building Services:
Contract language was modified outlining transition planning performance measures in all vendor contracts.
CSHCN staff are members of the Kansas Commission on Disability Concerns, The Kansas Commission on Developmental Disabilities, Shared Vision for Youth, Positive Behavior Support, and the Leadership Education Excellence in Neurodevelopmental Disabilities Program (LEND). CSHCN staff serve in an advisory capacity to family and youth support organizations.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Transition clinics for Cystic Fibrosis, Cerebral Palsy, Cleft Lip/ Palate and Spinal Cord are held regularly for the older youth.	X	X	X	
2. Education and Families Together, Inc conduct transition workshops for professionals and families. CSHCN staff provide input and are speakers at these events.	X	X	X	X
3. CSHCN staff participate in local, regional, state and national workshops, to promote inclusion and increase awareness of the needs of this population.		X	X	X
4. CSHCN staff represent the Secretary of the Kansas Department of Health and Environment on the Kansas Council on Disability Concerns and Kansas Council on Developmental Disabilities.			X	X
5. Transition information, notebooks and internet links are shared with families and professionals to support transition planning.	X	X	X	X
6. Kansas has utilized TA and handouts from the National	X	X	X	X

Healthy and Ready to Work Center. A Kansas specific transition toolkit is distributed at clinic visits, conferences & family support programs.				
7. Families Together, Inc. and the Parent Advisory Council provide input on current and future CSHCN transition efforts.		X	X	X
8.				
9.				
10.				

b. Current Activities
Direct Services:
Same as last year.

Enabling Services:
Continue to support transition planning efforts in the specialty clinics

Population-Based Services:
A family survey is being conducted that includes questions about transition planning and information needed to address transition topics.

Infrastructure Building Services:
In addition to last years activities, CSHCN is a stakeholder on the Kansas Health Policy Authority's Medical Home Initiative and Electronic Medical Record/ Personal Health Information Implementation that started in the later part of the year. CSHCN staff also joined the Shared Vision for Youth Initiative and attended the Regional peer to peer regional dialogue and planning session. CSHCN staff has taken a supportive role in the newly named Shared Vision for Youth project by engaging partners new to this endeavor. CSHCN formed a team including Disability Program Navigators, Families Together, Inc., and Kansas Youth Empowerment Academy to participate in a high school career fair. Over 800 families are expected to attend the career fair.

Kansas applied for and was awarded the 2009 Integrated Community Systems grant that includes engaging and supporting youth activities to provide and strengthen effective partnerships with providers, knowledge and skill building to support transition objectives within a medical home, education, community living, and work.

c. Plan for the Coming Year
Direct Services:
Same as last year.

Enabling Services:
In addition to last year's activities, CSHCN staff will continue to support expanded activities of Families Together, Inc. The Family to Family grant expands their current roles/expertise within the education arena to include health community partners and train/educate families about their roles in these partnership roles. The expansion of updated MADIN toll free line web site, information and services resources, and bilingual Administrative Specialist to support and promote geographic parity and cultural awareness.

Population Based Services:
Continue from previous years.

Infrastructure Building:
CSHCN will review current clinic practices based on the Physician and Family survey results and stakeholder's recommendations. Participate in a joint school carrier fair building on the strengths of each program and design a model to be used in other regions. CSHCN staff remain active

stakeholders in the Medical Home and e-personal health record discussions currently in the research and design phases.

The award of the Integrated Community Systems for Youth with Special Health Care Needs will allow us to strengthen patient, family, and professional partnerships through education, mentoring, technology, and financial investment to support culturally diverse family/youth involvement at all levels of decision-making. The State's transition priority will be reviewed at the MCHB Title V Needs Assessment meeting. We anticipate the efforts and gains made over the past 5 years including revised and expanded data collection practices and building upon collaborative partnerships of families and providers, that this state priority will continue to be supported.

State Performance Measure 9: *The percent of CSHCN families that experience financial problems due to the child's health needs*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			20	20	20
Annual Indicator	24.4	21.4	21.4	21.4	21.4
Numerator					
Denominator					
Data Source					National CSHCN 2005-2006. est KS
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	20	20	20	20	20

Notes - 2008
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006. Percentage of CSHCN whose conditions cause financial problems for the family.

Data for 2008 is not available. 2005-2006 data was used to pre-populate this performance measure. This indicator is comparable between 2005-2006 and 2001 National Children with Special Health Care Needs Survey.

Notes - 2007
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06; Percentage of CSHCN whose conditions cause financial problems for the family.

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measures. Indicator is comparable across survey years.

Notes - 2006
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06; Percentage of CSHCN whose conditions cause financial problems for the family.

Indicator is comparable across survey years.

a. Last Year's Accomplishments

Direct Services:
With reductions in State General Funds, and level Federal funding for many years, the CSHCN program has had to decrease direct services offered to clients again this past year. Staff continued to work with hospitals and other vendors to accept our rate of payment in full; however, some families have incurred increased out of pocket expenses. During multidisciplinary clinics, insurance coverage (public/private) was assessed. Families that were uninsured were given information about Medicaid/SCHIP and the CSHCN program. Families were encouraged to apply and/or were assisted with the application process. The CSHCN program continued to be the sole source of coverage for eligible conditions for undocumented residents.

Enabling Services:
Families that applied for the CSHCN program were required to apply for the State Medicaid/ SCHIP programs, unless they were screened out due to citizenship status on the CSHCN program application. The Medicaid/SCHIP applications in English and Spanish were labeled with the CSHCN program name with instructions for the Clearinghouse staff to figure a spend-down during the application process. CSHCN staff contacted the Clearinghouse to resolve problems when families reported problems. Equipment purchased with CSHCN funding was labeled with recycling information to reduce this line item expense. Interpreter and transportation services are prior approved by the CSHCN program as needed.

Population Based Services:
Performance measures documenting that insurance status is being reviewed was added to vendor contracts.

Infrastructure Building Services:
CSHCN staff ensured that billing had been completed with public/private insurance prior to CSHCN program payment. CSHCN contracting providers took CSHCN payments as "payment in full". Kansas monitors and reports on the impact of Federal actions on public insurance programs like S-CHIP and Medicaid. New CSHCN providers (specialists, primary care providers, pharmacies, therapists, and clinics serving the underservered population) continue to be added expanding the CSHCN contracted provider options.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Newborn screening was increased from 4 to 29 tests in 2008 and CSHCN is monitoring how this legislative change will impact families and services.	X	X	X	X
2. CSHCN has updated guidelines and information about expanded NBS.		X	X	X
3. Families applying for CSHCN are required to apply or SCHIP/Medicaid programs	X	X	X	X
4. Families are reminded to keep the EPSDT current for added program benefits and support.	X	X	X	X
5. CSHCN program collaborates with private organizations to fund eligible medically necessary treatment and equipment not otherwise covered.	X	X	X	X
6. Families are encouraged to recycle medical equipment to the Kansas Equipment Exchange program to be refurbished and		X	X	X

recycled				
7. Monitor legislative actions impacting current CSHCN funding activities			X	X
8. Families Together, Inc. and the Parent Advisory Council provide input on current and future CSHCN efforts.		X	X	X
9.				
10.				

b. Current Activities

Direct Services:
Provide training to assure that newborn screening tests are completed, collected, and processed in a correct and timely manner. The training has reduced the number of unsatisfactory tests so that interventions are initiated earlier, and hopefully, minimizing effects of chronic health conditions. Families experience less out of pocket expenses when they utilize EPSDT expanded benefits.

Enabling Services: In coordination with early intervention, injury prevention and car safety programs, efforts are being made to decrease avoidable disabilities and increase benefits of early intervention efforts.

Population Based Services:
Documented compliance of insurance status was unsatisfactory and was reviewed with vendors. Improvement in data reporting continues with ongoing education.

Infrastructure Building Services:
New CSHCN providers (specialists, primary care providers, pharmacies, therapist and clinics serving the underservered population) continue to be added expanding the CSHCN contracted provider options. CSHCN continues to work with providers and families to utilize alternative funding sources within local communities and disease specific foundation's programs to minimize the family's out of pocket costs.

c. Plan for the Coming Year

Direct Services:
The results of the expanded newborn screening program and financial impact upon limited CSHCN treatment resources will be monitored. This state performance measure will be reviewed at the Five Year Needs Assessment. With the current economic downturn, there is an increased demand on alternative funding resources which has nearly depleted capacity.

Enabling Services:
Means to effectively and efficiently use a broad range of resources will be a top priority during all planning sessions at the Five Years Needs Assessment.

Population Services: Early intervention, prevention of secondary disabilities, and intentional and unintentional injuries interventions need to be more strongly implemented to reduce the demand and burden on families to care for children who could remain healthy and disability free.

Infrastructure Building: High utilization and need for financial support continues to drive coordination and collaboration between service providers.

E. Health Status Indicators

Introduction

/2010/ Annual tracking on health status indicators contributes to Kansas' ability to: provide information on the State's residents; direct public health efforts; conduct surveillance and monitoring of health issues; and, evaluate the impact of interventions. Data for health status indicators 1-5 are routinely provided to policymakers as, for example, when considering appropriations for prenatal smoking cessation //2010//

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	7.3	7.2	7.2	7.1	7.1
Numerator	2890	2852	2942	2982	2982
Denominator	39553	39701	40896	41951	41951
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

The 2008 column is populated with 2007 data. 2008 data will be available Fall 2009.

Notes - 2007

Data Source: Kansas 2007 Annual Summary of Vital Statistics, Center for Health & Environmental Statistics, KDHE

Notes - 2006

Data Source: Kansas 2006 Annual Summary of Vital Statistics, Center for Health & Environmental Statistics, KDHE

Narrative:

/2010/ Reducing births with low birth weight (LBW) is a Kansas MCH priority in the MCH 2010, the 5-Year State MCH Needs Assessment. In Kansas, the percent of LBW declined slightly in 2007, to 7.1% from 7.2% in 2006 as seen in the United States. For 2007, the most recent year national data (preliminary) is available, the percent of Kansas births with LBW is 13.4% lower than for the U.S (8.2%). Overall, there was an increasing trend in the last decade as seen in the United States.

In 2007, small declines in total LBW were reported for the non-Hispanic White (6.9 to 6.8%) and Hispanic infants (5.7 to 5.6%). However, an incline was reported for the non-Hispanic Black infants (12.7 to 13.1%).

In Kansas, LBW is an important issue since 65.2% of all infant deaths occurred among the 7.1% of infants born at LBW. Similarly, 48.7% of infant deaths occurred among the 1.4% of infants born at VLBW.

Recent trends in LBW are influenced by the multiple birth rate. Twins and higher order multiples are much more likely to be born LBW than singletons. In 2007, 56.2% of all plural births in Kansas were LBW.

The risk of LBW was greater for smokers than for nonsmokers (11.8% versus 6.2%), creating an excess LBW risk of 5.6% associated with smoking. Other risk factors for LBW live births include low socioeconomic status, inadequate weight gain during the pregnancy, history of infertility problems, close inter-pregnancy spacing and age of mother.

Refer to NPM 15, 17, 18 and SPM 2 for the program efforts to reduce births with LBW. //2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	5.6	5.5	5.7	5.5	5.5
Numerator	2136	2117	2271	2244	2244
Denominator	38298	38405	39673	40630	40630
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Fall 2009.

Notes - 2007
Data Source: Birth certificate (resident) data, 2007, Center for Health & Environmental Statistics, KDHE

Notes - 2006
Data Source: Birth certificate (resident) data, 2006, Center for Health & Environmental Statistics, KDHE

Narrative:
/2010/ This health indicator removes the impact of multiple births on the low birth weight rate.
Over the ten year period (1998-2007), there was no significantly increasing or decreasing trend detected. In Kansas for 2007, the percent of singleton LBW births decreased 3.5% from 2006. For 2006, the most recent year national birth data (final) is available, the percent of Kansas singleton births with LBW is 11.8% lower than for the U.S. Refer to NPM 15, 17, 18 and SPM 2 for the program efforts to reduce births with LBW. //2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.4	1.3	1.3	1.4	1.4
Numerator	547	534	529	573	573

Denominator	39553	39701	40896	41951	41951
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Fall 2009.

Notes - 2007
Data Source: Kansas 2007 Annual Summary of Vital Statistics, Table 19, Center for Health & Environmental Statistics, Kansas Department of Health and Environment.

Notes - 2006
Data Source: Kansas 2006 Annual Summary of Vital Statistics, Table 18, Center for Health & Environmental Statistics, Kansas Department of Health and Environment.

Narrative:
/2010/ Kansas' VLBW rate was 1.4% in 2007. This is, a 7.7% increase from 2006. In the last decade (1998 - 2007), there was no significantly increasing or decreasing trend detected. In 2007, 82.8% of VLBW infants were born at facilities for high-risk deliveries and neonates a 4.2% decrease from 2006 (79.5%). For 2006, the most recent year U.S. birth data (final) is available; the percent of Kansas live births with VLBW is 13.2% lower than the U.S. percent.

Refer to NPM 15, 17, 18 and SPM 2 for the program efforts to reduce births with LBW. //2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.0	1.0	1.0	1.0	1.0
Numerator	388	376	396	421	421
Denominator	38298	38405	39673	40630	40630
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Fall 2009.

Notes - 2007
Data Source: Birth certificate (resident) data, 2007, Center for Health & Environmental Statistics, KDHE

Notes - 2006
Data Source: Birth certificate (resident) data, 2006, Center for Health & Environmental Statistics, KDHE

Narrative:
/2010/ This health indicator removes the impact of multiple births on the VLBW percent. In Kansas for 2007, 1.0% of live singleton births were VLBW, essentially the same as 2006. The last decade (1998 - 2007), there was no significantly increasing or decreasing trend detected. For 2006, the most recent year U.S. birth data (final) is available, the percent of Kansas singleton live births with VLBW is 12.4% lower than for the U.S.

Refer to NPM 15, 17, 18 and SPM 2 for the program efforts to reduce births with LBW. //2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	10.8	10.3	10.6	9.7	9.7
Numerator	61	57	61	56	56
Denominator	564421	555339	574097	575333	575333
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Fall 2009.

Notes - 2007
Data Source: Kansas 2007 Annual Summary of Vital Statistics, Table 56, Center for Health & Environmental Statistics, Kansas Department of Health And Environment.

Numerator: Number of deaths from all unintentional injuries (ICD-10 Coding, V01-X59, andY85-Y86) for children (residents) aged 14 years and younger for the reporting period.

Denominator: Number of children (residents) aged 14 years and younger for the reporting period. 2000 US Census (Bridged-Race Vintage series)

Notes - 2006
Data Source: Kansas 2006 Annual Summary of Vital Statistics, Table 55, Center for Health & Environmental Statistics, Kansas Department of Health And Environment.

Numerator: Number of deaths from all unintentional injuries (ICD-10 Coding, V01-X59, andY85-Y86) for children (residents) aged 14 years and younger for the reporting period.

Denominator: Number of children (residents) aged 14 years and younger for the reporting period. 2000 US Census (Bridged-Race Vintage series)

Narrative:
/2010/ In 2007, the death rate for children due to unintentional injuries was 9.7 per 100,000, a decrease from 2006 (10.6). Over the eight year period (2000-2007), there was a significant decreasing trend (p<0.05) detected in the rate of deaths due to unintentional injuries children aged 14 and younger. Over this same time period, Kansas unintentional injury death rates (ages 0-14) have been consistently higher than for the U.S. (28.6% in 2006, the most recent year with final U. S. death data).

To prevent mortality in this population, the MCH programs are collaborating with SAFE Kids and other community agencies. The Kansas Trauma Registry collects information on serious unintentional childhood trauma treated in Kansas hospitals, which will identify risk factors and suggest interventions to be implemented at the regional level. //2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	5.1	5.9	4.0	3.7	3.7
Numerator	29	33	23	21	21
Denominator	564421	555339	574097	575333	575333
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Fall 2009.

Notes - 2007
Numerator: Number of deaths from all unintentional injuries due to motor vehicle crashes for children (residents) aged 14 years and younger for the reporting period. Data Source: Kansas 2007 Annual Summary of Vital Statistics, Table 56, Center for Health & Environmental Statistics, Kansas Department of Health And Environment.

Denominator: Number of children (residents) aged 14 years and younger for the reporting period. Data Source: 2000 US Census (Bridged-Race Vintage series)

Notes - 2006
Numerator: Number of deaths from all unintentional injuries (ICD-10 Coding, V01-X59, andY85-Y86) for children (residents) aged 14 years and younger for the reporting period. Data Source: Kansas 2006 Annual Summary of Vital Statistics, Table 55, Center for Health & Environmental Statistics, Kansas Department of Health And Environment.

Denominator: Number of children (residents) aged 14 years and younger for the reporting period. Data Source: 2000 US Census (Bridged-Race Vintage series)

Narrative:

/2010/ In 2007, the death rate for children due to motor vehicle crashes was 3.7 per 100,000 down 7.5% from 4.0 per 100,000 in 2006. Over the eight year period (2000-2007), there was a decreasing trend detected, however, not statistically significant. For the same time period, Kansas motor vehicle crash death rates (ages 0-14) have been consistently higher than for the U.S.

MCH programs are collaborating with SAFE Kids and other community agencies. The Kansas Trauma Registry collects information on serious unintentional childhood trauma treated in Kansas hospitals, which will identify risk factors and suggest interventions to be implemented at the regional level. //2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	28.2	31.2	28.9	24.8	24.8
Numerator	118	130	120	102	102
Denominator	418546	416292	414560	410696	410696
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Fall 2009.

Notes - 2007
Numerator: Number of deaths from all unintentional injuries due to motor vehicle crashes for youth (residents) aged 15 through 24 years for the reporting period. Data Source: Kansas 2007 Annual Summary of Vital Statistics, Table 56, Center for Health & Environmental Statistics, Kansas Department of Health And Environment.

Denominator: Number of children (residents) aged 15 through 24 years for the reporting period. Data Source: 2000 US Census (Bridged-Race Vintage series)

Notes - 2006
Numerator: Number of deaths from all unintentional injuries due to motor vehicle crashes for youth (residents) aged 15 through 24 years for the reporting period. Data Source: Kansas 2006 Annual Summary of Vital Statistics, Table 55, Center for Health & Environmental Statistics, Kansas Department of Health And Environment.

Denominator: Number of children (residents) aged 15 through 24 years for the reporting period. Data Source: 2000 US Census (Bridged-Race Vintage series)

Narrative:
/2010/ In 2007, the death rate for youth in this age group due to motor vehicle crashes was 24.8/100,000 down 14.2% from 2006 (28.9%). Over the eight year period (2000-2007), there was a statistically significant decreasing trend detected. For this time period, Kansas motor vehicle crash death rates (ages 15-24) have been consistently higher than for the

U.S. (11.2% higher in 2006).

These data led to adoption of SPM 6 and collaborative efforts with SAFE Kids and other groups to address the issue. New legislation in the 2008 session imposes driving restrictions on teens and this will need to be tracked over time. //2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	284.0	270.1	256.2	271.8	271.8
Numerator	1603	1500	1471	1564	1564
Denominator	564421	555339	574097	575333	575333
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Spring 2010.

Notes - 2007
Numerator: Number of hospital discharges for resident children ages 14 years and younger with non-fatal unintentional injuries (E800-E869 and E880-E929). Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth th Center for Health and Environmental Statistics, KDHE.

Denominator: Number of resident children ages 14 years and younger in the reporting period. Data Source: 2000 US Census (Bridged-Race Vintage series).

Notes - 2006
Numerator: Number of hospital discharges for resident children ages 14 years and younger with non-fatal unintentional injuries (E800-E869 and E880-E929). Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth th Center for Health and Environmental Statistics, KDHE.

Denominator: Number of resident children ages 14 years and younger in the reporting period. Data Source: 2000 US Census (Bridged-Race Vintage series).

Narrative:
/2010/ In 2007, the rate of all nonfatal injuries among children ages 14 and younger was 271.8 per 100,000, a 6.1% increase from 2006 (256.2). The nonfatal unintentional injury rate was increased 1998-2004 and decreased to 2006 and then increased.

The most common causes of unintentional injury hospitalizations in this age-group are falls
followed by poisonings. To prevent morbidity and mortality in this population, the MCH programs are collaborating with SAFE Kids and other community agencies. The Kansas Trauma Registry collects information on serious unintentional childhood trauma treated in

Kansas hospitals, which will identify risk factors and suggest interventions to be implemented at the regional level. //2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	39.9	30.4	28.4	27.6	27.6
Numerator	225	169	163	159	159
Denominator	564421	555339	574097	575333	575333
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available Spring 2010.

Notes - 2007
Numerator: Number of hospital discharges for resident children ages 14 years and younger with non-fatal unintentional injuries due to MVC (E810-E825). Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth th Center for Health and Environmental Statistics, KDHE.

Denominator: Number of youth ages 15 through 24 for the reporting period. Data Source: U. S. Census - Bridged-Race Vintage series.

Notes - 2006
Numerator: Number of hospital discharges for resident children ages 14 years and younger with non-fatal unintentional injuries due to MVC (E810-E825). Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth th Center for Health and Environmental Statistics, KDHE.

Denominator: Number of youth ages 15 through 24 for the reporting period. Data Source: U. S. Census - Bridged-Race Vintage series.

Narrative:
/2010/ In 2007, injuries from motor vehicle crashes were the third leading cause of unintentional injury
hospitalization for this age group. The rate of nonfatal injuries due to motor vehicle crash was increased 1998-2003 and decreased 2004-2007.

This decrease in hospitalizations caused by MVCs can be attributed to the injury prevention efforts of MCH partners such as SAFE Kids and Kansas Department of Transportation. //2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	148.8	150.4	135.6	140.0	140.0
Numerator	623	626	562	575	575
Denominator	418546	416292	414560	410696	410696
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
The 2008 column is populated with 2007 data. 2008 data will be available in Spring 2010.

Notes - 2007
Numerator: Number of hospital discharges for youth ages 15 through 24 due to non-fatal injuries caused by motor vehicle crashes (E810-E825) in the reporting period. Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth th Center for Health and Environmental Statistics, KDHE.

Denominator: Number of youth ages 15 through 24 for the reporting period. Data Source: U. S. Census - Bridged-Race Vintage series.

Notes - 2006
Numerator: Number of hospital discharges for youth ages 15 through 24 due to non-fatal injuries caused by motor vehicle crashes (E810-E825) in the reporting period. Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth th Center for Health and Environmental Statistics, KDHE.

Denominator: Number of youth ages 15 through 24 for the reporting period. Data Source: U. S. Census - Bridged-Race Vintage series.

Narrative:
/2010/ Injuries from motor vehicle crashes are the leading cause of injury hospitalization among youth in this age group with the highest rate in the 15-19 year old age group. The rate of nonfatal injuries due to motor vehicle crashes to youth ages 15-24 increased from 1998-2001 and decreased from 2001-2007.

The decrease in hospitalizations due to motor vehicle crashes can be attributed to the injury
prevention efforts of MCH grantees and partners such as the Injury and Disability Program section in the Office of Health Promotion and the Kansas Department of Transportation. These groups have worked to increase seat belt usage (see SPM #6) in the 15-19 age group. They advocated for "graduated drivers' licensing" legislation and were successful. This legislation assures that teens have an opportunity to gain more experience under safer conditions before they become
fully-licensed drivers. //2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	24.2	25.2	27.2	28.4	28.1
Numerator	2384	2465	2663	2772	2742
Denominator	98564	97894	97842	97697	97697
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
DATA SOURCE:
Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data on incident cases reported for CY2008
Denominator= KDHE. Center for Health and Environmental Statistics
KIC - population for the state of Kansas. Because 2008 estimates are not available at the time of this application, 2007 data was used to pre-populate this field. Further information and data limitations can be found at http://kic.kdhe.state.ks.us/kic/popeth_table.html

Notes - 2007
DATA SOURCE:
Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data on incident cases reported for CY2007.
Denominator= KDHE. Center for Health and Environmental Statistics
KIC - population for the state of Kansas. Further information and data limitations can be found at http://kic.kdhe.state.ks.us/kic/popeth_table.html

Notes - 2006
Data Source

Numerator: STD data, Bureau of Disease Prevention and Control, KDHE.
Denominator: KIC - population for the state of Kansas.
http://kic.kdhe.state.ks.us/kic/popeth_table.html

Narrative:
/2010/ There continues to be statistically significant increase in teenagers being reported with Chlamydia over the last five years. However, this year's rate does not differ significantly from the rate reported last year--28.1 per 1000 versus 28.4 per 1000. Whites continue to make up the majority of the cases, but Chlamydia rates remain higher in minority populations--particularly among African-Americans. In 2008, this age group (comprising of both genders) accounted for 34% of cases reported to KDHE. //2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	7.8	8.0	8.3	8.9	9.8
Numerator	3678	3745	3825	4067	4508
Denominator	469976	468937	460954	458243	458243
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
DATA SOURCE:
Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data on incident cases reported for CY2008
Denominator= KDHE. Center for Health and Environmental Statistics
KIC - population for the state of Kansas. Because 2008 estimates are not available at the time of this application, 2007 data was used to pre-populate this field. Further information and data limitations can be found at http://kic.kdhe.state.ks.us/kic/popeth_table.html

Notes - 2007
DATA SOURCE:
Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data on incident cases reported for CY2008
Denominator=KDHE. Center for Health and Environmental Statistics
KIC - population for the state of Kansas. Further information and data limitations can be found at http://kic.kdhe.state.ks.us/kic/popeth_table.html

Notes - 2006
Data Source

Numerator: STD data, Bureau of Disease Prevention and Control, KDHE.
Denominator: KIC - population for the state of Kansas.
http://kic.kdhe.state.ks.us/kic/popeth_table.html

Narrative:
/2010/ There continues to be statistically significant increase in reported chlamydia cases for women 20-44. This year there was a 10.3% with 445 new cases reported. Chlamydia rates continue to be disproportionately high in minority populations. Based on self-reported ethnicity, statistically significant increases have been noted in young Hispanic adult females. This may be partially attributed to statistically significant increases in Chlamydia cases among non-Hispanic white and Hispanic young adult males reported over the last five years. In total, this age group of both genders contributes to 41% of cases reported to KDHE in 2008. //2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL	**Total All**	**White**	**Black or African American**	**American Indian or Native**	**Asian**	**Native Hawaiian or Other**	**More than one race**	**Other and Unknown**

POPULATION BY RACE	**Races**			**Alaskan**		**Pacific Islander**	**reported**	
Infants 0 to 1	40426	34745	4013	467	1201	0	0	0
Children 1 through 4	155712	134793	14717	1735	4467	0	0	0
Children 5 through 9	190372	165075	17730	2433	5134	0	0	0
Children 10 through 14	188823	165234	16563	2567	4459	0	0	0
Children 15 through 19	201815	177856	16925	2953	4081	0	0	0
Children 20 through 24	208881	183809	16438	3152	5482	0	0	0
Children 0 through 24	986029	861512	86386	13307	24824	0	0	0

Notes - 2010
DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2007, United States resident population from the Vintage 2007 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2008.

Note-- Asian and Pacific Islander racial categories have been combined.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2007, United States resident population from the Vintage 2007 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2008.

Note-- Asian and Pacific Islander racial categories have been combined.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2007, United States resident population from the Vintage 2007 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2008.

Note-- Asian and Pacific Islander racial categories have been combined.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2007, United States resident population from the Vintage 2007 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2008.

Note-- Asian and Pacific Islander racial categories have been combined.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2007, United States resident population from the Vintage 2007 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2008.

Note-- Asian and Pacific Islander racial categories have been combined.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2007, United States resident population from the Vintage 2007 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2008.

Note-- Asian and Pacific Islander racial categories have been combined.

Narrative:
/2010/ The racial distribution for Kansas children is about 87.4% white, 8.8% black or African-American, 1.3% American Indian or Native Alaskan, 2.5% Asian, and Others - negligible. From Table HSI #06B the ethnicity for all Kansas children 0 through 24 is 12.2% Hispanic or Latino. //2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	34333	6093	0
Children 1 through 4	132467	23245	0
Children 5 through 9	163716	26656	0
Children 10 through 14	165090	23733	0
Children 15 through 19	181319	20496	0
Children 20 through 24	188759	20122	0
Children 0 through 24	865684	120345	0

Notes - 2010
DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2007, United States resident population from the Vintage 2007 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2008.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2007, United States resident population from the Vintage 2007 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2008.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2007, United States resident population from the Vintage 2007 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2008.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2007, United States resident population from the Vintage 2007 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2008.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2007, United States resident population from the Vintage 2007 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2008.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2007, United States resident population from the Vintage 2007 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2008.

Narrative:
/2010/ The racial distribution for Kansas children in Kansas is about 87.4% white, 8.4% black or African-American, 1.3% American Indian or Native Alaskan, 2.5% Asian, and Others - negligible. From Table HSI #06B the ethnicity for all Kansas children 0 through 24 is 12.2% Hispanic or Latino. //2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	47	21	14	0	0	1	4	7
Women 15 through 17	1273	863	158	15	13	1	51	172
Women 18 through 19	2990	2273	351	32	23	5	77	229
Women 20 through 34	33031	27247	2179	234	904	46	488	1933
Women 35 or older	4601	3854	197	17	225	1	43	264
Women of all ages	41942	34258	2899	298	1165	54	663	2605

Notes - 2010
women <15 = women 10-14

Narrative:
/2010/ Live birth data by maternal age and race is readily available through Kansas Vital Statistics. Kansas started using the revised birth certificate in 2005 which allowed for

expanded race categories including native Hawaiian or other Pacific Islander and multi race.

For 2007 data, 98.4% of births were to women who only selected one race, while 1.6% selected two or more races. White race was selected for 81.7% of live births, black race 6.9% of live births, Asian 2.8% of live births, Native American 0.7% of live births, Native Hawaiian or other Pacific Islander 0.1%, and race was unknown for 0.2% of live births.

In 2007, women of Hispanic ethnicity accounted for 15.9% of live births. With the revised birth certificate, race data was collected in a different manner for Hispanic mothers. Before 2005, mothers of Hispanic origin were assigned white race unless they indicated another race. In the years 2002-2004, almost 1% (0.9%) of Hispanic mothers selected "other" race. In 2007, about 1 out of 3 (34.8%) selected "other race" as their race. Thus, the counts for white births through 2004 are not compatible with births by race from 2005 forward. With less Hispanics included in the white race data, certain percents or rates among white females may be affected such as teen pregnancy rates and smoking during pregnancy. //2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	27	20	0
Women 15 through 17	832	435	6
Women 18 through 19	2340	635	15
Women 20 through 34	28009	4935	87
Women 35 or older	3936	651	14
Women of all ages	35144	6676	122

Notes - 2010
women <15 = women 10-14

Narrative:
/2010/ Live birth data by maternal age and race is readily available through Kansas Vital Statistics. Kansas started using the revised birth certificate in 2005 which allowed for expanded race categories including native Hawaiian or other Pacific Islander and multi race.

For 2007 data, 98.4% of births were to women who only selected one race, while 1.6% selected two or more races. White race alone was selected for 81.7% of live births, black race was 6.9% of live births, Asian 2.8% of live births, Native American 0.7% of live births, native Hawaiian or other Pacific Islander 0.1%, and race was unknown 0.2% of live births.

In 2007, women of Hispanic ethnicity accounted for 15.9% of live births. With the revised birth certificate, race data was collected in a different manner for Hispanic mothers. Before 2005, mothers of Hispanic origin were assigned white race unless they indicated another race. In the years 2002-2004, almost 1% (0.9%) of Hispanic mothers selected "other" race.

In 2007, about 1 out of 3 (34.8%) selected "other race" as their race. Thus, the counts for white births up to 2004 are not comparable with births by race from 2005 forward. With less Hispanics included in the white race data, certain percents or rates among white females may be affected such as teen pregnancy rates and smoking during pregnancy. //2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	333	231	57	3	5	1	15	21
Children 1 through 4	38	28	1	1	0	0	2	6
Children 5 through 9	26	18	5	0	0	0	2	1
Children 10 through 14	36	30	4	0	0	0	0	2
Children 15 through 19	138	101	16	1	3	0	7	10
Children 20 through 24	178	148	17	2	0	0	2	9
Children 0 through 24	749	556	100	7	8	1	28	49

Notes - 2010

Narrative:
/2010/ The death certificate data for children by age group by race (HSI #08A) is readily available from Vital Statistics as is death certificate data for children by age group by ethnicity (HSI #08B). These tables are useful as a tool in public health planning and implementation efforts, as for instance when estimating the school age population for a particular intervention or when there is a need to pull together data quickly for a meeting.

In 2007, there were 749 deaths to children ages 0-24 with 333 of deaths to infants. Based on the proportion of Black or African-American children in the Kansas population, Black children have proportionately greater numbers of deaths than other races. Black children comprise 8.8% of the States' children but 13.4% of the deaths to children. Black infants comprise 9.9% of the States' infants but 17.1% of the deaths to infants. Hispanic children comprise 12.2% of the States' children but 15.8% of the deaths to children. Hispanic infants comprise 15.1% of the States' infants and 16.8% of the deaths to infants. These latter data suggest that there may be a slightly greater risk for Hispanic children as they age. //2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY	**Total NOT Hispanic or**	**Total Hispanic or**	**Ethnicity Not**

Total deaths	**Latino**	**Latino**	**Reported**
Infants 0 to 1	275	56	2
Children 1 through 4	23	14	1
Children 5 through 9	21	4	1
Children 10 through 14	30	6	0
Children 15 through 19	117	18	3
Children 20 through 24	158	19	1
Children 0 through 24	624	117	8

Notes - 2010

Narrative:
/2010/ The death certificate data for children by age group by race (HSI #08A) is readily available
from Vital Statistics as is death certificate data for children by age group by ethnicity (HSI #08B). These tables are useful as a tool in public health planning and implementation efforts, as for instance when estimating the school age population for a particular intervention or when there is a need to pull together data quickly for a meeting.

In 2007, there were 749 deaths to children ages 0-24 with 333 of deaths to infants. Based on the
proportion of Black or African-American children in the Kansas population, Black children have proportionately greater numbers of deaths than other races. Black children comprise 8% of the States' children but 15% of the deaths to children. Black infants comprise 9% of the States' infants but 17% of the deaths to infants. This is not the case for Hispanics. Hispanic children comprise 13% of the States' children but 15% of the deaths to children. Hispanic infants comprise 16% of the States' infants and 16% of the deaths to infants. These latter data suggest that there may be a slightly greater risk for Hispanic children as they age. //2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	777148	677703	69948	10155	19342	0	0	0	2007
Percent in household headed by single parent	37.8	18.4	52.7	26.9	17.7	0.0	39.4	33.7	2007
Percent in TANF (Grant) families	5.9	4.4	16.1	8.1	3.2	0.0	0.0	0.0	2008
Number enrolled in Medicaid	214260	159504	35537	4082	3356	249	0	11532	2008

Number enrolled in SCHIP	60156	48145	5913	824	1053	61	0	4160	2008
Number living in foster home care	9187	7050	1893	75	34	13	0	122	2008
Number enrolled in food stamp program	142329	100721	27799	2487	1835	170	3499	5818	2008
Number enrolled in WIC	91406	73449	11144	2117	1308	175	3213	0	2008
Rate (per 100,000) of juvenile crime arrests	3740.7	3528.8	6753.5	2150.1	1272.5	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	3.4	2.0	3.5	4.4	1.6	0.0	2.9	0.0	2007

Notes - 2010
DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2007, United States resident population from the Vintage 2007 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2008.

NOTE Asian and Pacific Islander racial categories have been combined together.

DATA SOURCES:
Overall Kansas Rate used U.S. Census Bureau. 2007 American Community Survey 1-Year Estimates. B11003.FAMILY TYPE BY PRESENCE AND AGE OF OWN CHILDREN UNDER 18 YEARS - Universe: FAMILIES. http://www.census.gov/acs/www/.
Race Specific Estimates used U.S. Census Bureau. 2007 American Community Survey 1-Year Estimates. B11001A-I. HOUSEHOLD TYPE (INCLUDING LIVING ALONE) - Universe: HOUSEHOLDS. Further information can be found at http://www.census.gov/acs/www/.
Numerator = sum of other family; male householder, no wife present and other family; Female householder, no husband present
Denominator = total Family households

Race specific estimates are not comparable with previous data. Because the table on households with children under 18 table is no longer updated by the U.S. Census Bureau, a proxy measure is used. This data includes families with children under 18 years of age and is updated annually.

DATA SOURCE: Kansas Department of Social and Rehabilitation Services (SRS). Unduplicated TANF (CASH) recipients in KS AGE 0 to 19 during calendar year 2008 based on self-reporting of race/ethnicity to SRS.

Note—Asian and Pacific Islander racial categories have been combined together.

DATA SOURCE: Kansas Health Policy Authority. - Title 19 race and ethnicity report, ages 19 and under, CY 2008.

DATA SOURCE: Kansas Health Policy Authority. - Title 21 race and ethnicity report, ages 19 and under, CY 2008.

DATA SOURCE: Kansas Department of Social and Rehabilitation Services (SRS). Unduplicated food assistance recipients in KS AGE 0 to 19 during calendar year 2008 based on self-reporting of race/ethnicity to SRS.

DATA SOURCE: KDHE. Bureau of Family Health. WIC program data. Calendar Year 2008 – KWIC Racial Statistics for clients 19 years of age and younger.

DATA SOURCE: Kansas Bureau of Investigation. Total arrests made youths aged 5-19, CY 2008.

Note: Asian and Pacific Islander racial categories have been combined. This data is not comparable with previous applications because the age range has been extended up to 19 years of age to be more in line with the form's specified age range.

DATA SOURCE:
Numerator=Kansas State Department of Education. KANSAS
UNIFIED SCHOOL DISTRICT DROPOUTS: 2003-2004 through 2007-2008.
Denominator=Kansas State Department of Education. KANSAS
STATE REPORTS. Enrollments by age, gender, race, and ethnicity 2007-2008.

Note: Due to administrative changes to comply with FERPA regulations, racial/ethnic estimates are not comparable with previous years' submissions. Racial and ethnic breakdown of school dropouts for 2007-2008 school year includes grades 7 through 12. Asian and Pacific Islander racial categories have been combined together.

DATA SOURCE: Kansas Department of Social and Rehabilitation Services (SRS Children and Family Services), children in out of home placement, State Fiscal Year 2008.

Narrative:
/2010/ This year, there was a slight increase (0.1% -- 593) in the number of Kansas children ages 0-19, with largest growth among African-Americans. This age group population has become increasingly diverse: 87% white, 9% African-American, 1% Native American and 2% other. Kansas Hispanics account for 15.9% of children in the 0-19 age grouping, about 1 in 7. Possibly in response to the continuing economic downturn, enrollment of 0-19 age children has increased in several government assistance programs: Medicaid, SCHIP, food stamps, and WIC. Similarly, high school drop out rates and juvenile crime rates have increased in this reporting year. //2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	676925	100223	0	2007
Percent in household headed by single parent	17.9	32.9	0.0	2007
Percent in TANF (Grant) families	5.6	7.9	0.0	2008
Number enrolled in Medicaid	165487	48773	0	2008

Number enrolled in SCHIP	44869	15287	0	2008
Number living in foster home care	8161	707	319	2008
Number enrolled in food stamp program	109953	26558	5818	2008
Number enrolled in WIC	61924	29366	116	2008
Rate (per 100,000) of juvenile crime arrests	3645.8	4460.7	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	2.2	4.1	0.0	2007

Notes - 2010

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2007, United States resident population from the Vintage 2007 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2008.

DATA SOURCES:
Ethnicity Specific Estimates used U.S. Census Bureau. 2007 American Community Survey 1-Year Estimates. B11001A-I. HOUSEHOLD TYPE (INCLUDING LIVING ALONE) - Universe: HOUSEHOLDS. Further information can be found at http://www.census.gov/acs/www/.
Numerator = sum of other family; male householder, no wife present and other family; Female householder, no husband present
Denominator = total Family households

Ethnicity specific estimates are not comparable with previous data. Because the table on households with children under 18 table is no longer updated by the U.S. Census Bureau, a proxy measure is used. This data includes families with children under 18 years of age and is updated annually.

DATA SOURCE: Kansas Department of Social and Rehabilitation Services (SRS). Unduplicated TANF (CASH) recipients in KS AGE 0 to 19 during calendar year 2008 based on self-reporting of race/ethnicity to SRS.

DATA SOURCE: Kansas Health Policy Authority. - Title 19 race and ethnicity report, ages 19 and under, CY 2008.

DATA SOURCE: Kansas Health Policy Authority. - Title 21 race and ethnicity report, ages 19 and under, CY 2008.

DATA SOURCE: Kansas Department of Social and Rehabilitation Services (SRS). Unduplicated food assistance recipients in KS AGE 0 to 19 during calendar year 2008 based on self-reporting of race/ethnicity to SRS.

DATA SOURCE: KDHE. Bureau of Family Health. WIC program data. Calendar Year 2008 – KWIC Racial Statistics for clients 19 years of age and younger.

DATA SOURCE: Kansas Bureau of Investigation. Total arrests made youths aged 5-19, CY 2008.

This data is not comparable with previous applications because the age range has been extended up to 19 years of age to be more in line with the form's specified age range.

DATA SOURCE:
Numerator=Kansas State Department of Education. KANSAS
UNIFIED SCHOOL DISTRICT DROPOUTS: 2003-2004 through 2007-2008.

Denominator=Kansas State Department of Education. KANSAS STATE REPORTS. Enrollments by age, gender, race, and ethnicity 2007-2008.

Note: Due to administrative changes to comply with FERPA regulations, racial/ethnic estimates are not comparable with previous years' submissions. Racial and ethnic breakdown of school dropouts for 2007-2008 school year includes grades 7 through 12.

DATA SOURCE: Kansas Department of Social and Rehabilitation Services (SRS Children and Family Services), children in out of home placement, State Fiscal Year 2008.

Narrative:
/2010/ This year had a slight increase of 0.1% (593) in the number of children in Kansas with largest growth seen in African-Americans. The population has become increasingly diverse with 87% white, 9% African-American, 1% Native American and 2% other. Kansas Hispanics account for 15.9% of children--about 1 in 7. In response to continuing economic downturn, enrollment has increased in government assistance programs of Medicaid, SCHIP, food stamps, and WIC. Similarly, high school drop out and juvenile crime rates are also elevated in this reporting year. //2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	449192
Living in urban areas	535902
Living in rural areas	161120
Living in frontier areas	18967
Total - all children 0 through 19	715989

Notes - 2010
DATA SOURCE: U. S. Census Bureau.
http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm 2007

Kansas Vital records definition of Metropolitan Counties was used in this analysis. These counties are: Butler, Douglas, Harvey, Johnson, Leavenworth, Miami, Sedgwick, Shawnee, and Wyandotte.

DATA SOURCE: U. S. Census Bureau.
http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm 2007

Kansas Vital records definition of urban and semi-urban counties were used in this analysis. Counties were included if they had population densities of 40 or more persons per square mile. These counties are: Douglas, Johnson, Sedgwick, Shawnee, Wyandotte, Butler, Crawford, Franklin, Geary, Harvey, Leavenworth, Lyon, Miami, Montgomery, Reno, Riley, and Saline.

DATA SOURCE: U. S. Census Bureau.
http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. 2007.

Kansas Vital records definition of rural and densely-settled rural counties were used in this analysis. Counties included had population densities between 6 and 39 persons per square mile. These counties are: Allen, Atchison, Barton, Bourbon, Cherokee, Cowley, Dickinson, Doniphan, Ellis, Finney, Ford, Jefferson, Labette, McPherson, Neosho, Osage, Pottawatomie, Seward,

Sumner, Anderson, Brown, Chautauqua, Clay, Cloud, Coffey, Ellsworth, Grant, Gray, Greenwood, Harper, Haskell, Jackson, Kingman, Linn, Marion, Marshall, Mitchell, Morris, Nemaha, Norton, Ottawa, Pawnee, Philips, Pratt, and Republic.

DATA SOURCE: U. S. Census Bureau.
http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. 2007.

Kansas Vital records definition of frontier counties was used in this analysis. Counties included had population densities that had fewer than 6 persons per square mile. These counties are: Barber, Chase, Cheyenne, Clark, Comanche, Decatur, Edwards, Elk, Gove, Graham, Greeley, Hamilton, Hodgeman, Jewell, Kearny, Kiowa, Lane, Lincoln, Logan, Meade, Morton, Ness, Osborne, Rawlins, Rush, Sheridan, Smith, Stanton, and Trego.

Narrative:
/2010/ Paralleling trends observed in our vital records. An increasing number of children are living in metro areas, 62.7% up from 60% of last year. Urban areas (74.8% of children) continue to gain as rural (22.5%) and frontier (2.6%) lose population to these economic hubs. //2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	2720000.0
Percent Below: 50% of poverty	4.9
100% of poverty	11.7
200% of poverty	30.6

Notes - 2010
DATA SOURCE: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey (CPS). Annual Social and Economic (ASEC) Supplement. POV46: Poverty Status by State: 2007 Below 185% and 200% of Poverty -- All Ages/1. Further information can be found at http://www.census.gov/hhes/www/macro/032008/pov/new46_185200_01.htm

DATA SOURCE: U.S. Census Bureau. 2005-2007 American Community Survey 3-Year Estimates S1703. Selected Characteristics of People at Specified Levels of Poverty in the Past 12 Months. Further information can be found at http://www.census.gov/acs/www/.

This column is not comparable with previous applications because of different information sources and methods.

DATA SOURCE: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey (CPS). Annual Social and Economic (ASEC) Supplement. POV46: Poverty Status by State: 2007 Below 100% and 125% of Poverty -- All Ages/1. Further information can be found at http://www.census.gov/hhes/www/macro/032008/pov/new46_100125_01.htm

DATA SOURCE: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey (CPS). Annual Social and Economic (ASEC) Supplement. POV46: Poverty Status by State: 2007 Below 185% and 200% of Poverty -- All Ages/1. Further information can be found at http://www.census.gov/hhes/www/macro/032008/pov/new46_185200_01.htm

Narrative:
/2010/ Thirty percent (30.6) of Kansans live below 200% of the federal poverty level (FPL). Almost twelve percent (11.7) live below 100% FPL and five percent (4.9) live below 50% FPL. Children are disproportionately represented among the poor. About 40% of Kansas children live in households with incomes <200% FPL and 6% live in households with incomes below 50% FPL. //2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	708000.0
Percent Below: 50% of poverty	6.0
100% of poverty	17.4
200% of poverty	40.1

Notes - 2010
DATA SOURCE: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey (CPS). Annual Social and Economic (ASEC) Supplement. POV46: Poverty Status by State: 2007 Below 200% and 185% of Poverty -- People Under 18 Years of Age. Further information can be found at http://www.census.gov/hhes/www/macro/032008/pov/new46_185200_03.htm

DATA SOURCE: U.S. Census Bureau. 2005-2007 American Community Survey 3-Year Estimates S1703. Selected Characteristics of People at Specified Levels of Poverty in the Past 12 Months. Further information can be found at http://www.census.gov/acs/www/.

This column is not comparable with previous applications because of different information sources and methods.

DATA SOURCE: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey (CPS). Annual Social and Economic (ASEC) Supplement. POV46: Poverty Status by State: 2007 Below 100% and 125% of Poverty -- People Under 18 Years of Age. Further information can be found at http://www.census.gov/hhes/www/macro/032008/pov/new46_185100_03.htm

DATA SOURCE: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey (CPS). Annual Social and Economic (ASEC) Supplement. POV46: Poverty Status by State: 2007 Below 200% and 185% of Poverty -- People Under 18 Years of Age. Further information can be found at http://www.census.gov/hhes/www/macro/032008/pov/new46_185200_03.htm

Narrative:
/2010/ Thirty percent (30.6) of Kansans live below 200% of the federal poverty level (FPL). Almost twelve percent (11.7) live below 100% FPL and five percent (4.9) live below 50% FPL. Children are disproportionately represented among the poor. About 40% of Kansas children live in households with incomes <200% FPL and 6% live in households with incomes below 50% FPL. //2010//

F. Other Program Activities

KWIC, the new web-based WIC data system, is fully implemented throughout the state. The data system ensures more timely access to participation and budget information, risk data for evaluation purposes, and annual unduplicated counts. The system serves as a model in the country and the Kansas program is providing consultation to other states that are considering adapting the Kansas system.

/2007/ Envision, the vendor that developed the KS Immunization Registry (KIR) has been awarded contracts to build new CSHCN and MCH data modules onto the KIR system. The MCH & CSHCN systems were outdated and lacked certain administrative, fiscal and programmatic tracking and reporting capabilities. //2007//

The Kansas Information for Communities (KIC) system on the KDHE website allows data users to prepare their own queries for vital event data such as births and pregnancies http://kic.kdhe.state.ks.us/kic/. The system is updated each year. MCH staff train local staff in use of the system for community needs assessment in selecting local MCH priorities. KIC started as an MCH SPRANS Project.

Kansas Infant-Toddler Services at KDHE purchased three PhotoScreeners and conducted a pilot project to determine the effectiveness of the new technology in detecting vision problems not detected using traditional tools and methods outlined in the Kansas Vision Screening Guidelines. This research project was expanded to additional sites with funding from the Kansas Lions Club.

The Sunflower Foundation provided funding for a WIC project to address nutrition and physical activity in young children. The project evaluated four different strategies for delivering physical activity and healthy eating behavior messages to young children participating in WIC programs.

BCYF staff were participants in the internal review process for the revision of Vital Statistics Certificates (Birth, Death, Marriage and Divorce). In the spring of 2003 MCH participated in meetings regarding suggested changes and merging of current certificates with the US Standard Certificates. The new system was implemented in January of 2005 although various components of the new system are still undergoing development such as the export files to congenital anomalies and newborn hearing screening.

The focus of the Kansas Robert Wood Johnson Turning Point project is development of capacity to address racial/ethnic disparities in health status. A key element in that effort is better understanding of health data related to minority health status and partnering with minority communities to improve the documentation of health and disease in those communities. One of the products of the project is the document, Racial and Ethnic Minority Health Disparities in Kansas. This was released at Spring 2005 Minority Health Conference in Lawrence, Kansas.

Kansas MCH participated in the Rhode Island Kids Count School Readiness Initiative. MCH participated on the five member state team. This group has evolved into the Early Learning Coordinating Council with oversight of the State Early Childhood Comprehensive Systems Plan. The composition of the group has evolved as well, with foundation and business support for early childhood efforts. BCYF staff participate in a number of early childhood/school readiness work groups.

CSHCN contracted with Envisage consulting to evaluate their current data system. The current system is inadequate given the needs of the program. Envisage provided the program with recommendations for a new data system which will be considered as part of the CSHCN strategic plan. Kansas is a recipient of the Champions for Progress Incentive Award. The award was used to convene a statewide stakeholder's meeting that focuses on CSHCN and their families. Regional meetings are planned for this summer.

KDHE staff is involved in discussions with SRS to ensure referral for evaluation to Part C Infant-Toddler Services of all children birth to three years of age who have been victims of a

substantiated case of abuse or neglect. KDHE plans to work with SRS and Part C providers across the state to assure appropriate evaluation and intervention for children identified with social/emotional/mental health needs through this process. Five percent of all children enrolled in KDHE, Part C Infant-Toddler Services are in foster care.

KDHE participates with the Kansas Department of Social and Rehabilitation Services in planning an annual Kansas Fatherhood Summit to promote healthy father/male involvement in the lives of children through collaborative efforts. We also serve with Kansas Citizens United for Rehabilitation of Errants (KS CURE) in planning mentoring programs for children of prison inmates to help maintain the family structure in this difficult circumstance.

The American Lung Association of Kansas continues to provide leadership through the Kansas Asthma Coalition (KAC) with focus on evidence-based diagnosis and treatment through provider and consumer education efforts. MCH staff continues to provide asthma education to school and public health department nurses and serve on the KAC providing training on "Indoor Air Quality Issues." This resulted in an American Lung Association "Lung Champion" award for efforts in providing indoor air quality and asthma management education.

MCH child and adolescent health staff hosted an Adolescent Vaccine Update Teleconference for Kansas School and Public Health Nurses. This teleconference was a collaborative effort by BCYF and the Kansas Immunization Program, and was funded by Aventis Pasteur Pharmaceuticals. BCYF staff received a National Customer Service Award in October, from Aventis Pasteur recognizing their efforts in protecting human life through immunization.

Kansas Home Visitation Training Task Force was formed in 2002 to address the need for consistent training for home visitation staff across multiple programs, including Head Start, Parents as Teachers, Healthy Start Home Visitors, Part C Infant Toddler Programs and others. The Nebraska Early Childhood Training Center curriculum was selected by the Task Force as the standardized curriculum for Kansas home visitors. Funding for this project was obtained from the Region VII ACF office and from the Kansas Head Start Collaboration Office.

/2007/Kansas continues to invest in the development of staff core competency and leadership skills. Three MCH staff have completed the Kansas Public Health Certification (CPH) course and three will complete the program this year. //2007//
/2010/ MCH concluded a four month training project in May of 2009 to expand the role of professional registered nurses practicing in public health and school settings as child care health consultants. Thirteen nurses representing all regions of Kansas were awarded certificates as Kansas Child Care Health Consultants (KCCHC). The new graduates are currently involved in a one-year evaluation research study through the School of Education, University of Kansas, to measure outcomes related to how the nurses implement their training and role as child care health consultants in their community. This intensive educational process was facilitated by Brenda Nickel using the child care health Consultation (CCHC) curriculum from the National Training Institute (NTI), University North Carolina at Chapel Hill. The curriculum has prepared the nurses to work collaboratively with professionals in early childhood and child care settings, as well as community partners who strive to promote healthy and safe child care, empowering families and linking providers and families to resources in their community. Child care providers need ready access to expert advice from a health care professional in their centers in development of policies and health/safety guidelines, individualized health care plans for children with special health needs while in child care and information, training and resources to assure quality child care. The Kansas CCHC curriculum included such topics as: national health and safety standards for out-of-home care; emergency preparedness; disease reporting; immunizations for children and child care providers; and injury prevention. The four-month training involved didactic content delivered in person and on-line. //2010//

G. Technical Assistance

FFY 05, Steps in Establishing a Birth Defects Information System

Senate Bill 418 passed in the 2004 Kansas legislative session. It creates, pending the availability of funding, a birth defects surveillance system. The statutory language is similar to that of model statutes for the State of Ohio. BCYF submitted an application to the CDC for funding of a birth defects surveillance system. The application was approved but not funded. Resources are not available to establish a surveillance system at this time. Some very limited components of a system are maintained within the BCYF.

Technical assistance was obtained from Judith Gallagher from Health Systems Research to develop a strategic plan in collaboration with members of the newly formed Child and Adolescent Health Council. The members adopted a plan for the coming year: review of screening statutes in the state and other screening issues such as tools in use by practitioners.

FFY 06, Review of Current Kansas Newborn Screening System and Recommendations for Expanded Newborn Screening.

The MCH/CSHCN staff developed and submitted a request for a team review, headed by Brad Therrell of the National Newborn Screening and Genetics Resource Center in Austin, Texas. This request is pending at the time of the application submission although an August, 2005 has been suggested. Members of the KPC, Child and Adolescent Health Council, and the Kansas Heartland Genetics Consortium will be invited to participate in this process as stakeholders.

/2007/ The NNSGRC technical assistance in August of 2005 brought a team of experts to Kansas: Brad Therrell, Director, NNSGRC; Frank Desposito, MD, Chair of the N.J. NBS Advisory Panel; Harry Hanon, NBS Quality Assurance Chief; Gary Hoffman, Director of the Wisconsin NBS Screening Laboratory; Julie Miller, Program Manager, Nebraska NBS Program; and Marie Mann, Project Officer for NBS at the MCHB. The team evaluated the current NBS system, explained the steps necessary to expand newborn screening to the ACMG recommendations. A comprehensive report was provided to the State in March of 2006. An advisory panel will develop a report and make recommendations to the 2007 Legislature. For FFY 07, NBS expansion continues to be our primary technical assistance need. Kansas will request additional consultation in developing a legislatively mandated report to the 2007 legislature with recommendations on XNBS. //2007//

/2009/ In the coming year, BFH will request technical assistance to address one of the following key priorities: 1) core data for periodic review by perinatal council members - what data should be reviewed at regular intervals? 2) basic intro training for BFH staff in Public Health Accreditation/Standards; 3) facilitation of joint Medicaid/MCH meeting to re-do the Title V/Title XIX Interagency Agreement. Each of these is needed. TA will be based on quality and availability of trainer/facilitator. //2009//

/2010/ The bureau of family health is requesting technical assistance on infant mortality reduction with an emphasis on black infant mortality. The blue ribbon panel on infant mortality, a subcommittee of the Governor's Child Health Advisory Committee, will develop recommendations for consideration by policy-makers in the 2010 and 2011 legislative sessions. TA consultants will help with a review of national-state-local data and an overview of the federal Healthy Start program, state child death reviews, and local fetal-infant mortality reviews and coalitions. Intervention stategies for Kansas will be developed for policy-maker review. //2010//

V. Budget Narrative

A. Expenditures

/2009/ Expenditures Narrative FFY 07

Form 3 - FFY 07 Block Grant partnership expenditures were as follows: $4,772,923 federal; $4,377,812 state; and $5,007,212 local. In comparison, for FFY 06, Block Grant partnership expenditures were: $4,714,706 federal; $3,873,142 state; and $4,413,563 local match. Comparing FFY 06 and FFY 07 there were increases in all expenditures categories.

In FFY 07, MCH spent federal dollars within the amount available and also compatible with the priority needs identified in the State Needs Assessment.

In FFY 07, the following KDHE programs expended federal MCH funding to support initiatives relating to maternal and child health: Office of Health Assessment $26,158; Director of Health $1,768; Office of Oral Health $69,418; Office of Local and Rural Health $43,578; and Child Care Licensing and Registration $142,024. Within the Bureau of Family Health (the MCH unit within KDHE) $355,274 in federal MCH funds was spent for staff and operating costs working in programs for Pregnant Women & Infants, and for Children & Adolescents. Staff and operating costs for the CSHCN program were $415,510. Nutrition consultation through the WIC program was $2,948.

Aid to Local agencies and contracts with providers for MCH services totalled $2,204,292 and CSHCN contracts and supplies totalled $941,538. Newborn screening follow-up expenditures (2 salaries) were $86,708, one epidemiologist salary and operating was $60,000. Expenditures for administration (2 salaries) $84,919, and indirect costs totalled $338,788.

Fiscal controls have been imposed to assure that expenditures of MCH dollars are in line with reductions. In actual dollars, Kansas has lost over $300,000 in federal dollars since FFY 94 so that the amount of the federal grant today is $4.7 million. In inflationary terms, the Kansas federal MCH grant has lost over 35% of its spending value. What cost $5 million (the FFY 93 funding level) would cost $7.3 million today when considering inflation. MCH dollars have been directed towards priority work with accountability for work performed. Dollars that would be better spent elsewhere are shifted when possible.

For FY 07, the PMI funding of $400,000 accounts, in large part, for the increase in State expenditures from FFY 06 to FFY 07.

Local agency expenditures data is obtained from the quarterly expenditure affidavits submitted by local agencies. All MCH local agencies meet contractual matching requirements of 40%, however, most provide a 100% plus match. A very few local health departments have had difficulties meeting minimal local matching requirements. We continue to monitor this situation as local budgets tighten.

Form 4 - Two other items relating to expenditures should be noted here: 1) When considering federal MCH funds only, the state meets its federal obligation of 30-30 that is, equity in funding for each of the three populations. When considering all Block Grant partnership expenditures, the Children and Adolescent (C&A) services funding is significantly greater than funding for CSHCN, less so for Pregnant Women & Infants (P&I). The reason for this twofold. First, CSHCN contracts require no local matching dollars. Secondly, MCH grants to local communities do not require services to CSHCN. Various solutions to address this have been proposed such as requiring CSHCN contractors to provide a match, or require that local MCH agencies serve children with special health care needs, and/or a combination of these. Such changes are not likely to take place in the near future.

Another item worth noting is that the funding paradigm has shifted in the MCH grants to local agencies. Previously, services were weighted towards pregnant women and infants through such programs as M&I and Healthy Start Home Visitor. After consolidation of these two grants with the Child Health grants to make one MCH grant, the instruction to local agencies was to allocate resources 50% to pregnant women and infants, and 50% to children and adolescents. Since there were already other aid to local grants focusing on youth services (e.g., teen pregnancy, disparity, school health) the effect of this change was a slight overallocation of resources to the C&A population group.

Form 5 - Direct health care expenditures are approximately 36% of the total MCH budget. Enabling services are 51% of the overall budget with population-based and core public health at 6% each.

With State expenditures of $4,377,812 in FFY 07, the State of Kansas is well within its required maintenance of effort requirement of $2,352,511.

Kansas meets its 75% matching requirement through use of State and local funds (91%). When considering both State and local matching funds, Kansas prvoides a 196% match.

Detailed information about the Federal-State Title V Block Grant Partnership is provided on the attached Excel spreadsheet. //2009//

/2010/ Form 3 - Expenditures for FFY 08 were $4,700,744 federal Title V, $4,707,827 state, and $5,928,079 local dollars. Federal and state expenditures are roughly equal. The state match is over the 75% required match - at 100% of federal funds. Local agencies provided a match of 126% of federal funding. From FFY 07 to FFY 08 there was only a slight increase in state matching dollars. The major increase of about $1 M was in local matching dollars due to reporting of actuals and not required local match. Local agencies are required to report actual expenditures on the quarterly affidavits of expenditure.

Form 4 - Expenditures for FFY 08 totaled $15,335,680. Funds were spent proportionally at 43% for pregnant women and infants, 41% children and adolescents, and 13% children with special health care needs. The agency meets the federal requirement that 30% of the federal funds must be spent for CSHCN and 30% must be spent for children and adolescents. When state dollars are factored in there is a slight disparity in funding for the CSHCN. When local matching dollars are factored in there is a major disparity in funding for CSHCN. None of the CSHCN contracts requires matching dollars.

Form 5 - Expenditures for FFY 08 were utilized as follows: 36% for direct services, 50% for enabling services, 7% for population-based services, and 7% for core public health services. CSHCN expenditures account for most of the direct services. MCH grants to local agencies account, in large part for the enabling services, prenatal care coordination and services for children and adolescents. Newborn screening expenditures comprise most of the population services. The core public health expenditures are mainly from within the department: child care, primary care, vital's office of health care information and MCH/CSHCN staffing.

Detailed information about the Federal-State Title V Block Grant Partnership is provided on the attached Excel spreadsheet. //2010//

An attachment is included in this section.

B. Budget

//2009// Budget Narrative FFY 09

Form 2 - For FFY 08, the Block Grant partnership budget was: $4,772,234 federal; $4,023,212 state; and $4,624,845 local match.

For FFY 09, the Block Grant partnership budget is: $4,700,774 federal; $4,659,442 state; and $4,261,972 local match. In very rough terms, overall Kansas Maternal and Child Health Services' funding is one-third federal, one-third, State, and one-third local funding. Another way of stating this is to say that the State provides nearly a 100% match for the federal dollars and so do the local agencies.

Comparing the two budgets, there is a decrease in federal dollars corresponding to the decrease in the amount of the federal award. The increase in State dollars is due to new newborn sreening funds for follow-up and treatment and to underbudgeting for CSHCN in FFY 08. A decrease in local agency matching funds is projected based on SFY 08 trends. Detailed information about the FFY 09 budget is provided in the attached Excel spreadsheet. The spreadsheet shows how Kansas plans to meet its 30-30 requirement with $1,524,389 (32%) of the federal grant allocated to children and adolescents and $1,495,435 (31%) allocated to children with special health care needs.

Form 3 - Kansas' budget for FFY 09 meets its maintenance of effort requirement of $2,352,511. The Title V matching requirement of 75% is achieved through projected State matching funds of $4,659,442 (99%). Kansas also anticipates receiving $4,261,972 in local match.

Form 4 - Of its overall MCH budget (fed, state/local match), Kansas allocates about $2.5 million to services for pregnant women and $2.5 for infants. Another $5.4 million is allocated to children and adolescents and $2.5 million for CSHCN.

Form 5 - Again, considering the overall MCH budget, about $5.2 million is allocated to direct services, $5.9 million to enabling services such as case management and transportation. Slightly less than $l million each to population-based services and to core public health infrastructure services.

As of July 1, 2007, the indirect cost rate for the Kansas MCH program went 14.4% to 20.1%. It is projected to go to up another percentage point as of July 1, 2008. Costs for administration of the program (for Kansas MCH this is defined as MCH administration and indirect costs) are within the 10% limit set in federal Title V law. At this time, Kansas is in compliance with all requirements of the law.

The full amount of the anticipated federal Title V award, $4,700,774 is budgeted for FFY 09.

The MCH/CSHCN Directors provide input into the allocation and budgeting process for the MCH Block Grant, into the state budget, and into the process of prioritizing programs for MCH resources based on the State MCH needs assessment.

The Children with Special Health Care Needs Section administers grant funding for medical specialty clinics and a statewide system of services for children and their families. Contracts for this section include:
Advanced Orthopedics - $10,800
Cerebral Palsy Research - $156,400
Center for Child Health & Development at KU - $169,340
Center for Child Health and Development, KU, Kansas City Office - $145,068
Department of Pediatrics at KU Medical Center - $163,759
Families Together, Inc. - $45,000
Wichita Medical Practice - $95,000

Via Christie Medical Center in Wichita - $18,000
Wesley Clinics, Wichita - $48,450
UKSM, Wichita Office $261,012
SIDS Network of Kansas - $75,000

In addition, Wichita Medical Research and Educational Foundation is reimbursed $14 per sickle cell lab test. The Kansas State Department of Education and the Kansas Department of Social and Rehabilitation Services provide federal funding of $34,730 total to support the toll-free number -- Make a Difference Information Network. The State Department of Education provides $7,000 for Special Child Clinics (rural outreach clinics (e.g., Oakley). In SFY 08, CSHCN received $208,000 new funds from Tobacco Settlement funds to help offset costs related to PKU formula. In SFY 09, CSHCN is receiving an additional $200,000 in Tobacco Settlement funds to help with diagnostic and treatment costs associated with expansion of newborn screening. So the total funding for CSHCN from Tobacco Settlement funds (called Children's Initiative Funds in Kansas) is now at $408,000.

The Children & Families Section administers MCH grant funding for local agencies relating to: perinatal and reproductive health services, and child and adolescent health services. The contracts for this section include: MCH-- 84 contracts with local health departments and other local agencies for coverage of all 105 counties; Family Planning -- 58 contracts with local health departments and 3 other local agencies for coverage of all counties. It is projected that there will be nine contracts for the Section 510 Abstinence Education program. Seven teen pregnancy prevention projects and six teen pregnancy case management projects are funded. There are 14 contracts for school nurse/public health nurse collaborative practice.

For more detail about the breakdown of the Federal State Title V Block Grant partnership, please see the attachment to this section.

Following is the list of MCH contracts with local agencies for SFY 09 -- totalling $4,085,776
Barber Co Health Dept $4,413
Barton Co Health Dept (multi county) $61,248
Butler Co Health Dept $51,244
Chase Co Health Dept $2,798
Chautauqua Co Health Dept $8,160
Cherokee Co Health Dept $30,176
Cheyenne Co Health Dept $3,083
Clay Co Health Dept $38,422
Cloud Co Health Dept $9,145
Coffey Co Health Dept $5,887
Cowley Co Health Dept $43,509
Crawford Co Health Dept $43,614
Dickinson Co Health Dept $37,333
Doniphan Co Health Dept B $9,989
Douglas Co Health Dept $70,409
Edwards Co Health Dept $6,173
Ellsworth Co Health Dept $3,194
Finney Co Health Dept $130,208
Ford Co Health Dept $66,442
Franklin Co Health Dept $23,576
Geary Co Health Dept $98,173
Gove Co Health Dept B $2,910
Grant Co Health Dept $8,606
Gray Co Health Dept $5,016
Greeley Co Health Dept - $5,595
Greenwood Co Health Dept $7,473
Hamilton Co Health Dept $6,565

Harper Co Health Dept $5,782
Harvey Co Health Dept $44,798
Haskell Co Health Dept $7,306
Hodgeman Co Health Dept $3,363
Jefferson Co Health Dept $17,213
Johnson Co Health Dept $215,615
Kearny Co Health Dept $5,268
Kingman Co Health Dept $7,286
Kiowa Co Health Dept $5,303
Labette Co Health Dept $31,759
Lane Co Health Dept $4,990
Leavenworth Co Health Dept $70,992
Lincoln Co Health Dept $4,403
Linn Co Health Dept $13,004
Lyon Co Health Dept $73,899
Marion Co Health Dept $9,240
Marshall Co Health Dept B $12,809
McPherson Co Health Dept $26,037
Meade Co Health Dept $4,409
Miami Co Health Dept $20,857
Mitchell Co Health Dept $13,521
Montgomery Co Health Dept $42,954
Morris Co Health Dept $4,699
Morton Co Health Dept $3,590
NEK (multi county) $92,645
Nemaha Co Health Dept $12,056
Neosho Co Health Dept $18,925
Osage Co Health Dept $14,864
Ottawa Co Health Dept $8,874
Pawnee Co Health Dept $5,904
Phillips Co Health Dept $9,341
Pottawatomie Co Health Dept $29,906
Pratt Co Health Dept $8,407
Rawlins Co Health Dept $2,165
Reno Co Health Dept $105,226
Republic Co Health Dept $6,763
Rice Co Health Dept $9,900
Riley Co Health Dept $115,225
Rooks Co Health Dept $48,751
Saline Co Health Dept $74,626
Scott Co Health Dept B $3,221
Sedgwick Co Health Dept $581,317
SEK (multi county) $40,225
Seward Co Health Dept $88,831
Shawnee Co Health Dept $454,592
Sheridan Co Health Dept $2,802
Stafford Co Health Dept $5,875
Stanton Co Health Dept $3,903
Stevens Co Health Dept $6,389
Sumner Co Health Dept $24,896
Thomas Co Health Dept $15,895
Wabaunsee Co Health Dept $6,539
Washington Co Health Dept $9,015
Wilson Co Health Dept $11,167
Wyandotte Co Health Dept $698,918
CHC of SE Kansas $54,571

Hays Area Children's Center $18,156
Mercy Hospital $63,245

Teen Pregnancy Prevention Contracts for SFY 09 -- totalling $356,694
Crawford Co Health Dept $47,111
Flint Hills Community Health Center $18,845
Ford Co Kids Count $55,431
Labette Co Health Dept $39,000
Wichita Family Services Institute $89,173
YWCA of Topeka $65,679
Finney Co Health Dept $41,455

Teen Pregnancy Case Management Contracts for SFY 09 -- $460,670
Four Co Mental Health Center $76,274
Hunter Health Clinic $73,034
Geary Co Health Dept $81,567
Douglas Co Health Dept $77,557
Wichita Family Services Institute $54,204

School-Public Health Nurse Collaboratives for SFY 09 -- $54,934
annual competitive process -- LHDs in Barber, Franklin, Greeley, Harvey, Haskell, Jefferson, Lane, Lincoln, Mitchell, Ottawa, Phillips, Rawlins, Sheridan, Thomas, Trego Counties

Pregnancy Maintenance Initiative contracts for SFY 09 -- $400,000
Bethlehem House of El Dorado, Catholic Charities, Family Life Services, Gerard House

SIDS Network of Kansas contract for SFY 09 -- $75,000

Women's Right to Know budget for SFY 09 -- $36,000

Detailed information about the Title V budget for FFY 09 is provided in the attached Excel spreadsheet.

//2009//

/2010/ Form 3 - Budgeted for FFY 10 is a total of $14 M. Of this amount, 33% is budgeted from federal Title V dollars, 29% from state dollars, and 38% from local dollars. Previously, federal and state dollars have been roughly equal. Due to state funding reductions of about $600,000 in the 2009 session, state dollars are now budgeted at 86% of federal. Still, the state match of 86% is over the 75% required match. Local agencies provided a match of 116% of federal funding. This is below the 126% reported for FFY 08. As funding for local agencies is discontinued, Kansas loses the ability to draw on local matching dollars.

Form 4 - Budgeted for FFY 10 is a total of $14,273,641. Funds are allocated proportionally at 40% for pregnant women and infants, 41% children and adolescents, and 18% children with special health care needs. The agency meets the federal requirement that 30% of the federal funds must be spent for CSHCN and 30% must be spent for children and adolescents. When state dollars are factored in there is a slight disparity in funding for the CSHCN. When local matching dollars are factored in there is a major disparity in funding for CSHCN. None of the CSHCN contracts requires matching dollars. Included in the 40% for pregnant women and infants is a budgeted amount for conduct of the expanded newborn screening Advisory Council meetings. Please see council membership and charter at:
http://www.kdheks.gov/newborn_screening/advisory_council.html
This includes room rentals and working luncheons for quarterly meetings at $450/meeting

x four per year = $1,800 per year. Council members bear the costs of their travel and per diem to the Topeka meetings and also the costs of cancellation of scheduled patients at their clinics.

Form 5 - The budget for FFY 10 allocates funding as follows: 36% for direct services, 50% for enabling services, 7% for population-based services, and 7% for core public health services. CSHCN expenditures account for most of the direct services. Shifting CSHCN from direct health care to systems-development activities will probably not occur in the near future as there is a greater demand for CSHCN financial assistance given the current economic downturn. MCH grants to local agencies account, in large part for the enabling services, prenatal care coordination and services for children and adolescents. Newborn screening expenditures comprise most of the population-based services. The core public health expenditures are mainly from within the department: child care, primary care, vital's office of health care information and MCH/CSHCN staffing.

Following is the list of CSHCN contracts with providers for SFY 10:
Advanced Orthopedic Associates - Wichita $10,800
Cerebral Palsy Research Foundation $154,753
Families Together, Inc - Wichita $45,000
KUMC Research Institute, Center for Child Health & Development - clinic support $169,340
KUMC Research Institute, Center for Child Health & Development - KC field office $145,068
KUMC Research Institute, Department of Pediatrics - $163,759
UKSM - Wichita Field Office $269,315
UKSM - Wichita Medical Practice Association - $95,000
Via Christi Regtional Medical Center - St. Francis - $18,000
Wesley Medical Center - $43,050
Wichita Clinic PA (Spasticity and Mobility Clinic) - $5,400
Totals - $1,119,485

The Children & Families Section administers MCH grant funding for local agencies relating to: perinatal and reproductive health services, and child and adolescent health services. The contracts for this section include: MCH-- 85 contracts with local health departments and other local agencies for coverage of all 105 counties; Family Planning -- 59 contracts with local health departments and 3 other local agencies for coverage of all counties. There will no be contracts for the federal Section 510 Abstinence Education program (discontinued in FY 10). There are no teen pregnancy prevention projects (state funding discontinued) and six teen pregnancy case management projects (MCH/Medicaid partnership). There are 12 contracts for school nurse/public health nurse collaborative practice and 2 Healthy Families projects.

For more detail about the breakdown of the Federal State Title V Block Grant partnership, please see the attachment to this section.

Following is the list of MCH contracts with local agencies for SFY 10:
Barber Co Health Dept $4,413
Barton Co Health Dept (multi county) $61,248
Butler Co Health Dept $51,244
Chase Co Health Dept $2,798
Chautauqua Co Health Dept $8,160
Cherokee Co Health Dept $30,176
Cheyenne Co Health Dept $3,083
Clay Co Health Dept $38,422
Cloud Co Health Dept $9,145
Coffey Co Health Dept $5,887
Cowley Co Health Dept $43,509
Crawford Co Health Dept $43,614

Dickinson Co Health Dept $37,333
Doniphan Co Health Dept B $9,989
Douglas Co Health Dept $70,409
Edwards Co Health Dept $6,173
Ellsworth Co Health Dept $3,194
Finney Co Health Dept $130,208
Ford Co Health Dept $66,442
Franklin Co Health Dept $23,576
Geary Co Health Dept $98,173
Gove Co Health Dept B $2,910
Grant Co Health Dept $8,606
Gray Co Health Dept $5,016
Greeley Co Health Dept - $5,595
Greenwood Co Health Dept $7,656
Hamilton Co Health Dept $6,565
Harper Co Health Dept $5,782
Harvey Co Health Dept $44,798
Haskell Co Health Dept $7,306
Hodgeman Co Health Dept $3,363
Jefferson Co Health Dept $17,213
Johnson Co Health Dept $215,615
Kearny Co Health Dept $5,268
Kingman Co Health Dept $7,286
Kiowa Co Health Dept $5,303
Labette Co Health Dept $31,759
Lane Co Health Dept $4,990
Leavenworth Co Health Dept $70,992
Lincoln Co Health Dept $4,403
Linn Co Health Dept $13,004
Lyon Co Health Dept $73,899
Marion Co Health Dept $9,240
Marshall Co Health Dept B $12,809
McPherson Co Health Dept $26,037
Meade Co Health Dept $4,409
Miami Co Health Dept $20,857
Mitchell Co Health Dept $13,521
Montgomery Co Health Dept $42,954
Morris Co Health Dept $4,699
Morton Co Health Dept $3,590
NEK (multi county) $92,645
Nemaha Co Health Dept $12,056
Neosho Co Health Dept $18,925
Osage Co Health Dept $14,864
Ottawa Co Health Dept $8,874
Pawnee Co Health Dept $5,904
Phillips Co Health Dept $9,341
Pottawatomie Co Health Dept $29,906
Pratt Co Health Dept $8,407
Rawlins Co Health Dept $2,165
Reno Co Health Dept $105,226
Republic Co Health Dept $6,763
Rice Co Health Dept $9,900
Riley Co Health Dept $115,225
Rooks Co Health Dept $48,751
Saline Co Health Dept $74,626
Scott Co Health Dept B $3,221

Sedgwick Co Health Dept $581,317
SEK (multi county) $40,225
Seward Co Health Dept $88,831
Shawnee Co Health Dept $454,592
Sheridan Co Health Dept $2,802
Stafford Co Health Dept $5,875
Stanton Co Health Dept $3,903
Stevens Co Health Dept $6,389
Sumner Co Health Dept $24,896
Thomas Co Health Dept $15,895
Wabaunsee Co Health Dept $6,539
Washington Co Health Dept $9,015
Wilson Co Health Dept $11,167
Wyandotte Co Health Dept $698,918
CHC of SE Kansas $54,571
Hays Area Children's Center $18,156
Mercy Hospital $63,245

Teen Pregnancy Prevention Contracts for SFY 10 -- none

Teen Pregnancy Case Management Contracts for SFY 10 -- $345,188
Four Co Mental Health Center $57,153
Hunter Health Clinic $54,719
Geary Co Health Dept $61,128
Douglas Co Health Dept $58,116
Wichita Family Services Institute $40,578
KUMC - Center for Research $73,494

School-Public Health Nurse Collaboratives for SFY 10 -- $50,035
annual competitive process -- LHDs in Barber, Franklin, Greeley, Harvey, Haskell, Jefferson, Lane, Mitchell, Ottawa, Phillips, Rawlins, and Trego Counties

Pregnancy Maintenance Initiative contracts for SFY 10 -- $199,113
Bethlehem House of El Dorado, Catholic Charities, Family Life Services, Gerard House

SIDS Network of Kansas contract for SFY 10 -- $75,000

Women's Right to Know budget for SFY 10 -- $15,000

Detailed information about the Title V budget for FFY 10 is provided in a spreadsheet attachment. //2010//

An attachment is included in this section.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.